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ABSTRACT

Hearings were held to: (1) receive "Healthy Children: Investing in the Future," an Office of Technology Assessment (OTA) study on cost-effective strategies for improving the health of mothers and children; and (2) consider reauthorization of the Federal Family Planning Program (FFPP), Title X of the Public Health Service Act. This document provides a summary of the OTA study and testimony; the text of the Family Planning Amendments Act of 1987; and testimony on the Federal Family Planning Program. Discussion covers several controversial aspects of the implementation of the FFPP, the legislation in relation to teen pregnancy and increased abortion among teenagers, the National Right to Life Committee's objections to school-based clinics and the legislation's provision of funding for contraceptive development and research, the contraceptive development activities of the National Institute of Child Health and Human Development, and the positions of the American College of Obstetricians and Gynecologists, Planned Parenthood Federation of America, Family Health Services, and others in support of the legislation. Materials submitted for the record by the American Civil Liberties Union Foundation; the National Association of Nurse Practitioners in Family Planning; the Organization for Obstetric, Gynecologic, and Neonatal Nurses; and the National Family Planning and Reproductive Health Association are included. (RH)

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MATERNAL, CHILD HEALTH, AND FAMILY PLANNING SERVICES

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HEARINGS

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

SECOND SESSION

FEBRUARY 25, 1988—HEALTHY CHILDREN: INVESTING IN THE FUTURE
APRIL 22, 1988—TITLE X OF THE PUBLIC HEALTH SERVICE ACT
(H.R. 3769)

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CONTENTS

Page

Hearings held on:

February 25, 1988 ... 1
April 22, 1988 ... 43
Text of H.R. 3769 ... 45

Testimony of:

Alexander, Duane, Director, National Institute of Child Health and Human Development, National Institutes of Health, Department of Health and Human Services ... 215
Cabaniss, Nabers, Deputy Assistant Secretary for Population Affairs, Department of Health and Human Services ... 51
Fox, Claude Earl, State Health Officer, Alabama Department of Public Health and also on behalf of American Public Health Association ... 84
Gasper, Jo Ann, former Deputy Assistant Secretary for Population Affairs, Department of Health and Human Services ... 90
Glasnow, Richard D., director of education, National Right to Life Committee ... 149
Herdman, Roger C., Assistant Director, Health and Life Sciences Division, Office of Technology Assessment ... 2
Jarman, Peggy, executive director, Planned Parenthood of Kansas ... 188
Klausmeier, Walter W., executive director, Family Health Service, Inc. of Centre County, PA ... 196
Nelson, Anita L., member, American College of Obstetricians and Gynecologists ... 176
Robertson, Ronald, General Counsel, Department of Health and Human Services ... 51
Schwartz, Michael, resident fellow in social policy, Free Congress Research and Education Foundation ... 140
Waggoner, Barbara, director, Ambulatory Women's Health Care Programs ... 203
Wagner, Judith L., Senior Associate, Health Program, Office of Technology Assessment ... 3
Weed, Stan E., director, Institute for Research and Evaluation ... 137
Windom, Robert E., Assistant Secretary for Health, Department of Health and Human Services ... 51

Material submitted for the record by:

American Civil Liberties Union Foundation, letter to Chairman Waxman, July 29, 1988 ... 313
National Association of Nurse Practitioners in Family Planning and Organization for Obstetric, Gynecologic, and Neonatal Nurses ... 236
National Family Planning and Reproductive Health Association, Inc., statement ... 242
Planned Parenthood Federation of America, Inc., statement ... 222

MATERNAL, CHILD HEALTH, AND FAMILY PLANNING SERVICES

Healthy Children: Investing in the Future

THURSDAY, FEBRUARY 25, 1988

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:30 a.m., in room 2322, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. Waxman. The meeting of the subcommittee will come to order.

Two years ago, the Subcommittee on Health and the Environment requested that the Office of Technology Assessment conduct a study on cost-effective strategies for improving the health of mothers and children. It was our expectation that with such information, we could better target limited Federal resources, in terms of both enhancing lives and saving dollars. The purpose of today's hearing is to receive the findings of this OTA report, "Healthy Children: Investing in the Future."

As this report makes clear, we as a nation have made great progress in improving the health status of our children. But as it also makes clear, we still have very far to go:

—Although the national infant mortality rate has continued to decline, the United States ranks 17th among industrialized countries in this key health indicator. Its position has not improved since 1980. This year alone, it is anticipated that almost 40,000 babies will die within their first year of life.

—In recent years, the percentage of babies born to women who receive late or no prenatal care has increased. In 1985, for example, nearly one-quarter of all infants were born to mothers who did not receive care during the critical first trimester of pregnancy.

—In 1984, over 1 million adolescents in the United States became pregnant. Most of these pregnancies were unintended and unwanted and many ended with the delivery of babies with low birthweight, the No. 1 cause of infant death.

As part of its request, the subcommittee asked OTA to outline specific policy options as to how the Federal Government could address these problems most cost effectively. The report we will hear about today identifies such strategies. Its top recommendations include expanding poor women's access to prenatal care and to improving poor children's access to physicians' care. I plan to introduce legislation next week that includes several of these suggestions.

The basic message of this OTA report is that a Federal investment in preventive services can yield large long-term dividends to the Nation, even if they show up as short-run costs on the Federal ledger. It is a message well worth remembering as the 1989 budget battle begins and is one, I hope, will be heard by all committees of jurisdiction.

With this study [see p. 19], OTA has identified cost-effective opportunities to improve the health and lives of our children. The Federal Government cannot afford to ignore them. The payoff is simply too great.

Our two witnesses today are senior members of the study team responsible for the development and production of the OTA healthy children report.

Dr. Roger Herdman is Assistant Director of the Office of Technology Assessment and is head of OTA's Division of Health and Life Sciences.

Dr. Judith Wagner is a senior associate within the health program of OTA. Dr. Wagner served as Project Director for the OTA Child Health Study.

Thank you both for joining us this morning. We have already received your prepared statement as well as a summary of the study's findings and recommendations. All of that will be included in the record of today's hearings.

We would like to ask you to take just 5 minutes or so to summarize the statement and then we will have some questions for you. We would like to hear from you both before the questions begin.

STATEMENTS OF ROGER C. HERDMAN, ASSISTANT DIRECTOR, HEALTH AND LIFE SCIENCES DIVISION; AND JUDITH L. WAGNER, SENIOR ASSOCIATE, HEALTH PROGRAM, OFFICE OF TECHNOLOGY ASSESSMENT

Mr. **Herdman**. Thank you, Mr. Chairman. We are pleased to present our report, "Healthy Children: Investing in the Future" to you, a report which the subcommittee requested and which also was requested by the Senate Committee of Labor and Human Resources. I am going to make a few remarks and then turn the microphone over to Dr. Wagner.

Mr. Chairman, the report is sharply focused. The issues here are those which are of interest to the Congress. We certainly could have said more on the subject of income maintenance, the subject of adequate housing, the subject of dental care, mental health, screening for lead. All of these do have impact on children's health. We chose, at your suggestion, to emphasize a few issues stressing cost effectiveness, strategies which are practical and implementable, and budgetary responsibility as "Investing in the Future" implies.

Let me emphasize the following findings: The United States can do better in preventing health problems in infants and in young children. A substantial number of young children have not received their recommended immunizations. Children who live in poverty bear more than their share of the burden of illness and death. Racial differences in infant and childhood mortality are substantial.

Access to medical care is jeopardized for a substantial number of American children without any health insurance. Between 14 and 19 percent of all children under age 13, roughly 6.3 to 8 million children, have no health insurance coverage. Dr. Wagner will discuss the strategies which OTA has identified.

STATEMENT OF JUDITH L. WAGNER

Ms. WAGNER. Thank you. Mr. Chairman, OTA identified seven strategies for improving children's health through either prevention or improved access to medical care. We have listed the seven strategies on the poster on the side for easy reference. I am going to discuss just three of those this morning, but we would be happy to entertain questions on any of the others.

The three that I want to focus on in the prepared remarks are prenatal care, well-child care, and access to medical care. The seven strategies, briefly, are to improve access to prenatal care for poor women, to improve access for appropriate well-child care for poor children, to encourage the use of child safety restraints in automobiles, to improve poor children's access to medical care, to expand newborn screening programs to include additional tests, to encourage the development of comprehensive school-based clinics for adolescents, and to encourage the development of nurse home visitor programs for pregnant women and infants at high risk of low birthweight and child abuse and neglect.

Let me start with the first of the three. The first and foremost among the strategies that we identified is improving access to early prenatal care for poor women. This is both effective and cost-saving to the health care system. We assessed the evidence on the effectiveness of early or enriched prenatal care on low birthweight and infant mortality.

Despite serious shortcomings in the design of almost all studies of prenatal care effectiveness, the weight of the evidence from more than 55 studies that we examined supports the contention that low birthweight and infant mortality can be improved with earlier or more comprehensive care, especially in high risk groups such as adolescents and poor women.

If prenatal care can improve birth outcomes, the logical next question is whether a specific strategy to increase such care is worth its costs. We looked at how health care costs to the U.S. health care system—not just to Medicaid—would be affected by a policy of universal eligibility for Medicaid of all pregnant women in poverty.

We estimated that for every low birthweight birth avoided by earlier or more frequent prenatal care, the U.S. health care system saves between $14,000 and $30,000 in newborn hospitalization costs, in rehospitalizations in the first year of life, and in the long-term costs associated with disability that often accompanies low birthweight.

We found that the cost of providing the extra prenatal care to society or to the health care system as a whole would be about $4 million nationally, and that these extra costs would be more than made up for by the savings due to the reduction in low birthweight that we can expect, given the evidence on the effectiveness of prenatal care.

In short, we found that encouraging poor women to obtain early prenatal care through expanded Medicaid benefits is a good investment for the Nation.

One option for this committee to consider—and I gather that the committee is already considering this option—would be to make eligibility for Medicaid benefits mandatory for all pregnant women in poverty. This would not necessarily lead to net savings to the Medicaid Program itself, because Medicaid would pay for prenatal care that was formerly paid for by other sources. It is our best judgment that it would yield net savings to the health care system as a whole.

The second strategy that I would like to focus on in the prepared remarks is to encourage appropriate well-child care. OTA examined the evidence on the effectiveness and cost-effectiveness of well-child care and many of its components. The cost-effectiveness of the eight childhood vaccines routinely offered to children in the United States is well established.

These vaccines not only confer medical benefits but are cost-saving to the U.S. health care system. Even the recent increases in vaccine prices brought about by the vaccine liability crisis have not changed that basic fact. The recommended immunization schedule for children requires seven visits in the first 6 years of life. Adherence to this schedule of well-child care visits, which usually includes other services as well as immunization and which we assume would take place, is cost-saving to the U.S. health care system.

We do not know whether well-child care at more frequent intervals than the seven visits required for complete immunization is cost-effective because the effectiveness of other components of well-child care has not been established in the studies completed to date.

What we do know is, making sure that children do get the seven well-child care visits in the first 6 years of life is a sound investment and that Congress might look for ways to ensure that low-income children actually get that level of service.

One barrier to adequate well-child care is the low rate of payment that physicians get for EPSDT and regular Medicaid visits compared to private fees in many States. This discourages physicians from participating in Medicaid or EPSDT. Congress could encourage or require States to increase Medicaid fees paid to physicians for EPSDT screening visits or regular Medicaid checkups that correspond to the seven visit immunization schedule.

The third strategy is to improve poor children's access to physicians' care. Medicaid is clearly a great benefit for eligible children. It increases these children's access to medical care that has been proven effective. When children are sick, there are effective therapies available and they need to have access to them.

The recent optional expansions of the eligibility under OBRA-87, which permits states to offer Medicaid to infants at 185 percent of the Federal poverty level and to children through age 8 in poverty, will undoubtedly be implemented only by a portion of the States, perhaps in a minority of the States.

By making Medicaid eligibility mandatory for all poor children through a certain age—perhaps 5 or 8—Congress would reduce or eliminate this disparity among States that will result from the optional provisions. While this option that we propose would improve the health of newly eligible Medicaid children by increasing their use of effective health care, it would also be likely to increase both Medicaid and health system costs because it would bring about more use of medical care by these children.

For children who are already eligible for Medicaid, the key problem is finding adequate sources of care. Physician participation in the Medicaid Program varies from place to place, but it is limited both by low Medicaid fees and by administrative procedures that physicians find unpredictable and complex.

In general, Medicaid fees lie well below the fees paid by private patients. And the disparity grows every year. Between 1982 and 1984, for example, private physician fees increased by about 13 percent while the median Medicaid fee for a brief office visit remained virtually unchanged.

Congress could address the problem of low Medicaid fees for physicians who treat children by requiring States to increase these fees for services provided to children. Increased fees would raise Medicaid Program costs, however, and could encourage some unnecessary use of health services by Medicaid children. These problems need to be weighed against the benefits of increased access to effective care.

We should also emphasize that real Federal funding of programs such as the maternal and child health services block grant, community health centers and migrant health centers, has seriously eroded over the past 10 years. Between 1978 and 1986, at the same time that the proportion of children in poverty rose dramatically, Federal appropriations for these three programs declined by 32 percent in constant dollars.

Increasing real funding for direct provision for health care services to the poor through these programs is another way to expand access to needed medical care for poor children.

By definition, however, the funding of public or publicly subsidized clinics for the poor tends to separate provision of care for poor children and pregnant women from care given to the nonpoor. The implications of separate streams of medical care for poor and nonpoor children are unclear.

While targeted programs can offer enhanced services tailored to the multiple needs of poor children and their families, the quality and effectiveness of such services are likely to vary widely across areas. Without freedom to use other settings of care made possible by access to public or private health insurance, some poor women and children could receive low quality of care.

These problems deserve consideration as the Congress considers ways of making effective care more available to low income children.

That concludes my prepared remarks. Dr. Herdman, do you have any other comments?

Mr. **Herdman**. Just two more items, Mr. Chairman. I will be very brief on this. I just want to clarify and amplify two points which are in the report.

First, some have worried that OTA is suggesting less care and fewer well-child visits. This is not the case. OTA is emphasizing seven visits which deliver immunizations and could also deliver hearing and vision screening and other components of preventive care, and if necessary, diminishing six lesser priority visits by shifting funds to enhance payment for the cost-saving immunization visits.

This budget neutral option is to ensure essential well-care. Mr. Chairman, these visits are not only cost-saving, they are life saving.

Second, OTA has found that the slowing in improvement in infant mortality recently may be in part a change in reporting. That is, increased categorization of very low birthweight high mortality babies as live births rather than fetal deaths. There are other reasons which may be responsible. For example, lesser investment in prenatal care.

The point, however, is not this statistic or any reasons for its change. Mr. Chairman, the low birthweight and infant mortality rates are unacceptable. We can do better. Prenatal care works and it saves money as well as lives.

That concludes our report, Mr. Chairman. We would be happy to entertain questions.

[The prepared statement of Mr. Herdman and Ms. Wagner follows:]

TESTIMONY OF
ROGER HERDMAN, M.D., ASSISTANT DIRECTOR, AND
JUDITH L. WAGNER, PH.D., SENIOR ASSOCIATE
OFFICE OF TECHNOLOGY ASSESSMENT,
U.S. CONGRESS

BEFORE THE
HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

February 25, 1988

HEALTHY CHILDREN: INVESTING IN THE FUTURE

Mr. Chairman, it is our pleasure to appear before you with the results of an assessment of children's health that we conducted at your request and at the request of the Senate Committee on Labor and Human Resources.

As you know, OTA was asked to examine the effectiveness and costs of selected strategies for promoting and maintaining the health of children and to identify strategies whose implementation could substantially improve children's health or lower health care costs. The Committees also wanted to know why the infant mortality rate in the United States does not appear to be declining as fast as it has in the past and whether children have access to the health care they need.

The OTA assessment addressed all of those issues. This testimony summarizes the major findings of the study and lays out options that the Congress might want to consider in its effort to improve the health of America's children.

Despite many gains, the United States could do better in preventing health problems in infants and young children. As you know, in 1985, the Nation ranked 17th among industrialized countries in infant mortality, a position that showed no improvement in the previous five years. A substantial number of young children have not received their recommended immunizations--in 1985, over 20 percent of all 2-year olds in the U.S. were not fully immunized against measles. Furthermore, children who live in poverty bear more than their share of the burdens of illness and death. Racial differences in infant and childhood mortality are substantial, with black babies experiencing twice the level of infant mortality as white babies. Finally, access to medical care is jeopardized for the substantial number of American children without any health insurance. In 1986, between 14 and 19 percent of all children under age 13--roughly 6.3 to 8 million children--had no health insurance coverage; 61 percent of these uninsured children were from poor or near-poor families.

OTA identified seven strategies for improving American children's health through prevention or improved access to medical care. Three of the strategies would be both effective and cost-saving to the U.S. health care system; two are effective though not cost-saving; and two are promising new approaches that appear to merit greater funding for demonstrations and evaluations. The seven strategies are as follows:

Improving access to early prenatal care for poor women (effective and cost-saving) -- The high U.S. infant mortality rate in the United States is due in large measure to the high incidence of low birthweight births (defined as births under 5 lbs., 8 oz.). In 1980, low birthweight infants represented less than 7 percent of all live births reported in the United States but accounted for 60 percent of all infant deaths. Once birthweights are taken into account, U.S. infant mortality rates are comparable to or even lower than rates in other countries with much lower overall infant mortality rates.

OTA assessed the evidence on the effectiveness of early or enriched prenatal care on low birthweight and infant mortality. Despite serious shortcomings in the design of most studies of prenatal care effectiveness, the weight of the evidence from more than 55 studies supports the contention that low birthweight and infant mortality can be improved with earlier or more comprehensive care, especially in high-risk groups such as adolescents and poor women. Although the evidence clearly supports the effectiveness of prenatal care, it is less revealing about the size of the effect that can be expected from any given increase in the quantity or quality of prenatal care received by any segment of the population.

If prenatal care can improve birth outcomes, the logical next question is whether a specific strategy to increase access to such are is worth its costs. OTA performed a cost-effectiveness analysis to determine how costs to the U.S. health care system (not just to Medicaid) would be affected by a policy of universal eligibility for Medicaid of all pregnant women in poverty.

OTA estimated that for every low birthweight birth averted by earlier or more frequent prenatal care, the U.S. health care system saves between $14,000 and $30,000 in newborn hospitalization, rehospitalizations in the first year, and the long-term health care costs associated with low birthweight.

How effective would earlier prenatal care need to be for the extra prenatal care costs among newly eligible women--estimated at $4 million--to be outweighed by the savings resulting from a reduction in the rate of low birthweight? We estimated that the expansion of eligibility for prenatal care benefits under Medicaid would have to prevent between 133 and 286 low birthweight births among the 194,000 newly eligible women for the societal health care savings to outweigh the costs. The reduction in low birthweight births would be concentrated in the group of poor women whose use of prenatal care changed as a result of the expanded eligibility for Medicaid. If these women began with a low birthweight rate of 10.2 percent, that rate would have to decline by between 0.4 and 0.8 percentage points to a rate of between 9.4 and 9.8 percent for health care costs to break even.

Is it reasonable to expect reductions of this magnitude in the low birthweight rate among the women who take advantage of the expanded Medicaid benefits? The evidence on the impact of early prenatal care on birthweight suggests that such reductions are quite feasible. The quantitative results of several reasonably well-designed studies of the effect of early prenatal care on birthweight showed effects that were at least twice as great as the effects required for the expansion of Medicaid eligibility to pay for itself in reduced health care costs. Of course, early prenatal care can also be expected to prevent some infant deaths (though the number cannot be predicted with certainty), further enhancing the strategy's cost-effectiveness. Encouraging poor women to obtain early prenatal care through expanded Medicaid benefits is a good investment for the Nation.

Congress has already given the States the power to extend Medicaid eligibility to pregnant women with family incomes up to 185 percent of the Federal poverty line. States have always varied widely in Medicaid eligibility and benefit standards, however, and there is no reason to think that the variation will be reduced under a program with voluntary participation by the States. One option for Congress to consider would be to make eligibility for Medicaid benefits mandatory for all pregnant women in poverty. This strategy would not necessarily lead to net savings to the Medicaid program itself, because Medicaid would pay for prenatal care that was formerly paid for by patients, by other State programs, or provided by physicians and hospitals without compensation, but it would yield net savings to the health care system as a whole.

Expanding eligibility for Medicaid will not necessarily bring about early prenatal care unless other barriers to early care are also removed. In some States, the Medicaid enrollment process is complicated and lengthy and can delay the receipt of care for poor women. States could be encouraged or required to develop simplified eligibility requirements and procedures for pregnant women to enroll in Medicaid. Simple actions, such as placing Medicaid enrollment personnel in health clinics where many poor women first come for prenatal care, might encourage many women to sign up early for Medicaid.

Some providers have been reluctant to offer care to pregnant women in anticipation of their eligibility for Medicaid because of the fear of retroactive denial of eligibility and nonpayment for the services rendered. Under the presumptive eligibility section of OBRA-86 (P.L. 99-509), a "qualified provider" can provide services to a pregnant woman who is presumed to be eligible and be guaranteed of Medicaid reimbursement for that care even if eligibility is ultimately denied. "Qualified" providers include health departments, hospitals, and clinics, but not private physicians' practices. Thus, the presumptive eligibility clause of OBRA-86 appears to channel pregnant women who are probably eligible for Medicaid into sources of prenatal care other than private physicians. Relaxing the definition of a "qualified provider" would assure private physicians of some Medicaid reimbursement even if eligibility is ultimately denied and would encourage private physicians to accept poor women for prenatal care.

Encouraging appropriate well-child care (effective, cost-saving) -- Well-child care, consisting of immunizations, screening tests, and guidance for parents, is offered by physicians or other health professionals at defined points in a child's life. These preventive services are intended to improve the physical, cognitive, and psychological health of children. OTA examined the evidence on the effectiveness and cost-effectiveness of well-child care.

Immunization provides the starkest example of the power of prevention to save or prolong lives, prevent significant disability, and lower medical care costs. The cost-effectiveness of the eight childhood vaccines routinely offered to children in the United States is well established in the literature. These vaccines not only confer medical benefits but are cost-saving to the U.S. health care system. Even the recent increases in vaccine prices brought about by the vaccine liability crisis have not changed that basic fact. Expert groups in the United States currently recommend an immunization schedule for children that requires seven visits in the first 6 years of life. Adherence to this schedule of well-child care visits, which usually includes other services as well as immunization, is cost-saving to the U.S. health care system.

We do not know whether well-child care at more frequent intervals than the seven visits required for complete immunization is cost-effective, because the effectiveness of other components of well-child care has not been established in the studies completed to date.[1] It may be that more frequent visits do have modest impacts on children's health, but that these impacts have gone undetected because the studies conducted have been too small. Some outcomes, such as child development, have not even been addressed in most studies. What we do know is that making sure that children do get the seven well-child care visits in the first 6 years of life is a sound investment and that Congress might look for ways to ensure that low-income children actually get that level of service.

For children who are eligible for Medicaid, access to well-child care services is provided through either the regular Medicaid program or the EPSDT program. Thirty-two States explicitly allow Medicaid providers to bill for routine checkups for children under the regular Medicaid program. All States must provide for periodic health screening visits under the EPSDT program. Yet, the limited evidence on the immunization status of young children suggests that a substantial proportion of poor children do not receive all the immunizations that they should. One obvious problem is that the low rates of payment that providers get for EPSDT and regular Medicaid visits compared to private fees in many States discourage physicians from participating in Medicaid or EPSDT. Congress could encourage or require States to increase Medicaid fees paid to physicians for EPSDT screening visits or regular Medicaid checkups that correspond to a seven-visit immunization schedule.

Improving poor children's access to physicians' care (effective)--The frequency with which American children see a physician when they are sick depends very much on their income and their health insurance coverage. The lower the family income, and the less generous the health insurance coverage, the fewer services a child uses. Unfortunately, parents don't appear to be very good in differentiating between conditions for which medical care is highly effective and those for which it is not. When parents take their sick children to the doctor less frequently for financial reasons, they reduce effective and ineffective care in equal measure. Thus, the financial and other barriers to access faced by poor and near-poor children translate into less effective care for these children.

Medicaid is clearly a great benefit for eligible children. Very poor children, who have access to Medicaid, are more similar to middle-income children in the frequency of use of medical care than are other poor or low-income children, although they tend to receive that care in health clinics, hospital outpatient departments and emergency rooms more frequently than do middle-income children.

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[1] This assessment of well-child care excluded consideration of preventive dental services for children.

Congress has been expanding Medicaid eligibility for children since 1984. By July 1988, all children through age 6 who meet the income and resource requirements of the Aid to Families with Dependent Children (AFDC) program, regardless of whether they are actually eligible for AFDC, will be eligible for Medicaid. The AFDC income standards are State-specific, however, so the eligibility criteria are still varied and, in many States, stringent. In 1986, less than one-half of all American children under 13 years of age in poverty were covered by Medicaid. OBRA-86 gave States the right to extend Medicaid on a phased-in basis to all children under 5 years of age whose incomes and resources put them below the Federal poverty line. As of January 1988, only 26 States had extended eligibility beyond the required levels. The recent optional expansions of eligibility under OBRA-87 (P.L. 100-203), which permit States to offer Medicaid to infants whose family incomes are below 185 percent of the Federal poverty level and to children up through age 8 with family incomes below the poverty line, will undoubtedly be implemented by only a minority of States.

By making Medicaid eligibility mandatory for all poor children through a certain age (such as age 5 or 8), Congresswould reduce or eliminate the inevitable disparity among States that will result from the optional provisions of OBRA-87. While this option would improve the health of newly eligible Medicaid children by increasing their use of effective health care, it would also be likely to increase both Medicaid and health system costs because it would bring about more use of medical care by these children.

For children who are eligible for Medicaid, the key problem is finding adequate sources of care. Physician participation in the Medicaid program varies from place to place, but it is limited both by low Medicaid fees and by administrative procedures that physicians find unpredictable and complex. In general, Medicaid fees lie well below the fees paid by Medicare, which are in turn lower than those paid by private patients. The disparity grows every year. Between 1982 and 1984, for example, private physicians' fees increased by about 13 percent, while the median Medicaid fee for a brief office visit remained virtually unchanged. Studies of physicians' willingness to treat Medicaid patients have generally shown that participation rates are sensitive to the Medicaid fee level. One study showed that while low fees to private physicians did not result in fewer overall visits for Medicaid children, they did result in a shift in the site of care to hospital clinics and outpatient departments. In 1980, almost one-half of all physician visits by Medicaid children were in clinics, hospital outpatient departments, or emergency rooms.

Congress could address the problem of low Medicaid fees for physicians who treat children by requiring States to increase fees for services provided to children. Increased fees would raise Medicaid program costs, however, and could encourage some unnecessary use of health services by Medicaid children.

An alternative to expanding Medicaid eligibility and increasing fee levels for Medicaid providers would be for Congress to increase direct Federal subsidies of health care providers that offer primary health care for low-income families. Real Federal funding of programs such as the Maternal and Child Health Services Block Grants, community health centers, and migrant health centers has seriously eroded over the past ten years. Between 1978 and

1986, at the same time time that the proportion of children in poverty rose dramatically, Federal appropriations for these three programs declined by 32 percent in constant 1978 dollars.

Increasing funding for direct provision of health services to the poor has the advantage of permitting States or localities to target services to areas of greatest need and to tailor programs to the needs of poor women and children. Programs of enriched prenatal care, for example, can be more easily coordinated through State or local governments or community health centers than through physicians' private practices.

By definition, however, the funding of public or publicly subsidized clinics for the poor tends to separate provision of care for poor children and pregnant women from care given to the nonpoor. The implications of separate streams of medical care for poor and nonpoor children are unclear. While targeted programs can offer enhanced services tailored to the multiple needs of poor children and their families, the quality and effectiveness of such servicesare likely to vary widely across areas. Without freedom to use other settings of care, made possible by access to public or private health insurance, some poor women and children could receive lower quality care.

Expanding newborn screening to include tests for additional disorders (effective)--Newborn screening for PKU and congenital hypothyroidism, two diseases that cause irreparable mental retardation if not treated early in life, has unquestionably reduced net societal health care costs. Today, all States have newborn screening programs for these two congenital disorders. Issues for newborn screening programs involve decisions about expanded screening to include more tests or to screen babies a second time to avoid missing cases on the first specimen. We examined the cost-effectiveness of several expanded screening protocols and found that one protocol--screening for maple syrup urine disease and galactosemia in addition to PKU and congenital hypothyroidism on a single specimen--would detect an additional 68 affected infants at a net cost to the U.S. health care system of between $85,000 and $277,000 per case detected and treated. This cost range, though seemingly high, is in line with investments currently made for other medical procedures.

New tests are now available for relatively common conditions, including sickle cell anemia and cystic fibrosis. Although information is lacking for estimating the cost-effectiveness of screening for these disorders, newborn screening combined with prophylactic antibiotic therapy for babies with sickle cell anemia has been shown to be effective. To better determine if such tests can be cost-effective, the Federal Government could increase funding for research on such newly developed tests.

Encouraging the use of child safety restraints in automobiles (effective, cost-saving)--Accidents are the leading cause of death in U.S. children after the first few months of life, and about 15 percent of all accidental deaths to children under age 15 occur to children riding in motor vehicles. State laws requiring the use of child safety restraints in automobiles have indisputably reduced deaths and serious injuries in very young children and are therefore highly likely to be cost-saving to the U.S. health care system.

All States currently have laws requiring the use of infant or child restraints, but some laws are more rigorous than others. For example, 38 States have no restraint requirements for children over age 5, and many States do not require restraints for children over 3 or 4 years old. To encourage States to adopt effective laws, the Federal Government could promulgate a model child safety restraint law and require States seeking Federal highway funds to enact it.

Two additional promising strategies for improving children's health --We found two other strategies for improving children's health that are promising but need further study. They are comprehensive school-based clinics for adolescents at risk of unwanted pregnancy and nurse home visitor programs for pregnant women and infants in families at high risk of low birthweight births or child abuse or neglect.

School-based clinics that offer family planning services to teenagers at high risk of unwanted pregnancies and low birthweight births may be effective in reducing rates of pregnancy and births. Only two such programs have been evaluated to date, but both programs showed some success in this area. More evaluation of both the costs and effectiveness of this rapidly growing approach to delivering health services to high-risk teenagers would provide valuable information in the formation of future policy.

Providing home visitors to high-risk families is a labor-intensive and therefore costly strategy for reducing the incidence of low birthweight and child abuse and neglect, but the few available studies of its effectiveness are generally quite positive. More needs to be learned about how to target families who can most benefit from these services and the most effective and efficient configuration of services to offer.

Conclusions--By necessity, OTA's assessment of strategies for promoting children's health was selective and limited largely to personal health services. Other strategies, not examined in this report, may also be good investments. It is also worth noting that the environment in which children are born and raised may have as much to do with their health, broadly defined, as do the personal health care services they receive. The options raised in OTA's assessment might best be viewed as incremental steps that can be taken now to improve certain aspects of children's health and that would be reasonable components of a national policy on children.

Mr. **Waxman**. Let me thank you both for an excellent presentation, and commend you on the work that you have done. I think this is an excellent report and it will be very helpful for the Congress in deciding how to develop effective strategies for improving child health in this country.

I want to ask you some questions. Currently, only 26 States have taken the advantage of the option to extend Medicaid coverage to pregnant women with incomes below 100 percent of the Federal poverty level.

In your report you suggest that in order to prevent low birthweight and, in turn, to reduce infant mortality, Congress could mandate Medicaid coverage for all poor pregnant women. I agree, and I will be introducing legislation next week to implement this policy.

This policy will, of course, cost money, perhaps as much as $200 to $300 million per year in new Federal outlays. How would you persuade a Member concerned about the Federal deficit that this investment is necessary?

What do you say to a State which argues that its limited revenue base simply does not allow it to spend anymore Medicaid funds?

Ms. **Wagner**. Mr. Chairman, that is a very good question. In the very near future we will be talking to some State legislators about this very issue.

In my view, the purpose of Federal funding of health care services for the poor is to provide services that have value to people. If we were interested totally in saving Federal dollars we might not offer any services to the poor. That would certainly be a way to limit the Federal expenditures in this area.

When we make investments in health care, we are making those investments in order to achieve value. In the case of prenatal care for poor women, that value comes in reduced infant mortality, saving babies lives. We don't know exactly how many but we do know that is value right there.

And, interestingly enough also, a saving in health care costs that are borne by other segments of society by the private sector, by business and by consumers themselves. By making a public investment we are reaping returns on that investment in the private sector and also giving value to our citizens.

Mr. **Waxman**. As you note in your report, it is not enough just to make pregnant women and children eligible for Medicaid. If these groups are to have access to health care services, we also have to increase participation in the program by obstetricians, pediatricians and family practitioners.

You suggest that Congress could require States to increase the fees paid to physicians when they care for children eligible under Medicaid. Do you have any estimate as to how high fees would have to be raised to assure adequate physician participation?

Ms. **Wagner**. That is a very difficult, technical question. What we do know is that as Medicaid fees are increased or reduced relative to private fees, that there is a systematic relationship with the number of services that physicians will offer to Medicaid patients. We do know there is a relationship between that spread between private and Medicaid fees and participation rates.

As that spread is reduced, as Medicaid fees are increased, we can expect more participation to take place. How high the fees have to be is an empirical question that we are unable to answer at this time. I think what we need to do is focus on getting Medicaid fees closer to private fees. They don't necessarily have to equal private fees but they have to come within some reasonable range of private fees in order to induce the level of participation that would give these poor children access to mainstream medicine.

Mr. **Waxman**. In asking my next question, I would like you to take on the role of being a Member of Congress for a few minutes. If the Budget Committee told you that an additional $200 million Federal dollars were available next year for improvements in child health, what cost-effective strategies would you choose to enact into law?

Ms. **Wagner**. That's an interesting question.

Mr. **Waxman**. If they tell you that, will you share that information with me?

Ms. **Wagner**. Yes. It's delightful to be in your position.

Mr. **Waxman**. I think I might agree with your recommendations to them, but before you send them in officially, I think I would like you to share them with me.

Ms. **Wagner**. It's delightful to imagine ourselves in your position. I think we would talk about two. One is clearly the prenatal care, expansion of prenatal care to women in poverty. Yes, it would cost Medicaid money. Federal dollars, as well as State dollars, but that is so clearly a cost-saving intervention.

A second strategy that I think would be relatively inexpensive to implement in terms of Federal outlays and would have immediate impacts would be to use the Federal highway funding authority to encourage States to enact rigorous, strong child safety restraint laws for children.

It is not a personal health services strategy, but it is a strategy that could have immediate effects on children's injuries and on medical care costs with relatively limited Federal outlays. Those are two that I think would be very high priority.

Mr. **Waxman**. The OTA report suggests that the availability of family planning services is effective in helping to reduce the number of unintended and unwanted teen pregnancies. There was a little discussion, however, about the importance of these services in helping to reduce infant mortality rates of women of all ages.

What evidence is there that access to family planning services helps lower infant death rates?

Ms. **Wagner**. We actually did try to look at that question, Mr. Chairman, and we had difficulty answering it in the course of our project.

Family planning services are offered to low-income women. Low-income women, women in poverty, tend to have higher rates of low birthweight and consequently, higher neonatal and infant mortality rates. Preventing unwanted births among low-income women presumably would decrease infant mortality rates in these areas by the number of births times their infant mortality rates.

The problem that we had in looking at family planning in general, is that the goals of family planning programs extend widely beyond the reduction of infant mortality. The benefits of family planning are so much broader in scope beyond infant mortality and in low birthweight.

They have so many benefits to low-income women, independent of their impacts on infant mortality and low birthweight, that we found it almost too narrow to look at family planning within the context of our study which was more narrowly focused.

But certainly, it would have some impact on infant mortality and on low birthweight rate in these groups if unwanted pregnancies were able to be avoided in these groups of women.

Mr. **Waxman**. I guess that's an obvious answer. Family planning services allow women to avoid unintended pregnancies. Family planning services help prevent pregnancies for those most likely to have difficulties in getting the kind of prenatal care that pregnant women need.

But it seems to me that there is another benefit from the family planning program, and that's that it provides the first opportunity that many women, both teenagers and older women, have to gaining access to the health care system at all. They go into a family planning clinic and they get some entry into the health care system earlier than might have otherwise have been the case.

Do you see that as one of the benefits of family planning as well?

Ms. **Wagner**. Certainly, a large proportion of the visits, the first visits to the family planning agencies are for pregnancy testing. To the extent that family planning agencies then act as referral agencies into sources of prenatal care, they are a very powerful impetus to getting prenatal care at the time that it can make a difference to these women.

Yes, we would see that as a value. We didn't examine that particular aspect of family planning, but I think that it is a value.

Mr. **Herdman**. We do know, Mr. Chairman, that the school-based clinics which I think Dr. Wagner is aware of and has looked into, are clinics which have family planning services and where teenagers go presumably to get family planning services. But those clinics are, in fact, much more broadly based in terms of offering health services because they are—it is important not to limit them to family planning services.

That makes your point more strongly, that teenagers will go to those clinics perhaps drawn by the need for family planning services. But they will then be in a clinic which is a general health care clinic.

Mr. **Waxman**. I understand that your report did not discuss the benefits of screening for lead poisoning, a disease that can lead to severe disability and mental retardation.

In the work that I have done on this issue and particularly in the environmental area, it has become ever more clear to me that lead poisoning remains a major health problem for our children, and that we need to have adequate screening programs in place.

Isn't it true that lead poisoning is still a significant health problem for our young children? Can it be prevented with adequate detection programs? Haven't the programs that have been studied been proven cost-effective?

Ms. **Wagner**. Well, I regret to say to you Mr. Chairman, that we didn't examine the question of lead poisoning in our report. That does not in any way suggest that your conclusions and the findings of your subcommittee's deliberations are not true.

We had to make choices and be selective in where we wanted to look, and we did not look in environmental areas in general. We didn't look also at water fluoridation and some other kinds of environmental strategies where—there is evidence to suggest that they do have powerful impacts on children's health. We were selective.

I want to say also one point. We did, in looking at indicators of children's health status, point out that in the area of elevated blood levels which is a good indicator of children's health status, there has been a real decline of monitoring and surveillance of children's blood levels at the State and local levels in this country.

We don't have good monitoring systems to keep track of this potentially debilitating health problem and the extent of the problem.

Mr. **Waxman**. Your report raises questions about the number of preventive health visits that should be made by children during their early years. I don't think we need to determine the magic number here today, but I would like to get your views on the importance of early vision and hearing screens, particularly for those at higher risk of having or developing deficiencies.

Doesn't it make sense to catch these problems early on?

Ms. **Wagner**. Our report did not look directly at vision screening. That is another area where we were selective. We didn't look at vision screening. I think that is an important area that we might look at in the future.

With respect to hearing screens, we did look at the value of early hearing screening in the preschool period. The evidence is equivocal. The question is to what extent early preschool hearing screening, that is asymptomatic screening when there is no detectable symptoms, actually is a good predictor of permanent hearing problems in children.

The literature is very difficult to interpret and it has equivocal findings. I guess our answer is simply that we don't know from the evidence that is available, just how valuable preschool hearing screening programs or hearing screening would be.

Mr. **Waxman**. We talked about school-based clinics having an important role in making family planning services available to adolescents.

We held a hearing last spring of this subcommittee on school-based clinics. At those hearings we learned that, in fact, these programs provide a lot more than just contraceptive services. Is what you found in your work on school-based clinics—that these other services have been effective in dealing with the health problems of adolescents, other than teenage pregnancy?

Ms. **Wagner**. The majority of school-based clinics do not offer prescribing or dispensing of contraceptives. Many of these don't even provide family planning services.

What they do offer is a variety of counseling, physical examination and health services for minor problems, and referral for more major problems that are found for adolescents. We looked at these school-based clinics really from the vantage point of the extent to which, when they offer family planning services they can be effective in reducing unwanted pregnancies among high risk teenagers.

That was our particular handle on it. We were not looking at the overall health impacts on adolescents. It is true that these services can't even be provided in schools without offering a broader array of services. They will not be accepted by students unless they are seen as comprehensive services.

So even when they do offer family planning services, they must offer a broader, more comprehensive array of services. We did not look at the question of how effective these services are for teenagers. There is no reason to think that they are not effective, but we don't have specific information.

Mr. **Waxman**. You have as your sixth strategy, school-based clinics for at risk adolescents; what did you mean by that?

Ms. **Wagner**. We were more specific in the report. What we meant in the report, we looked at programs—school- based comprehensive health services programs for teenagers who have high rates of sexual activity and high rates of unwanted pregnancy.

We looked at the evidence on the impact of those services on pregnancy rates, sexual activity rates, and birth rates in the schools. This is an area where the evaluative evidence is very preliminary. There are only two studies of the impacts on pregnancy and birth rates of school-based clinics that offer family planning services.

More evaluation is currently going on right now, with 100 or so school-based clinics that exist in the country and will get more information over time on this.

What we wanted to highlight is that this is a potentially effective way to go about reducing infant mortality and low birthweight in a particularly vulnerable population that is at risk for having unwanted pregnancies that end up with very poor birth outcomes. That was our particular vantage point for looking at school-based clinics.

We did not look at the health of adolescents as a group per se in this report. We focused on young children and infants. School-based clinics came in through the impact on infant mortality and low birthweight that their services might potentially have.

We hope in the future there is some interest in looking at adolescent health in and of itself in the future.

Mr. **Waxman**. I would be interested in some of your conclusions when you do look at that issue as well.

I want to commend you on your presentation and in the work you have done. It has been very helpful to us. We will share this with our colleagues widely and we will share it with the Budget Committee. We hope the report can convince them that we need more money to spend in this area where the payoff is really enormous both in terms of human life and savings of dollars and cents.

Ms. **Wagner**. If we can be of any help, we would be delighted. Thank you, Mr. Chairman.

Mr. **Waxman**. Thank you. That concludes our hearing this morning. We stand adjourned.

[Whereupon, at 10:15 a.m., the hearing was adjourned.]

[The Office of Technology Assessment report follows:]

Healthy Children
Investing in the Future

Summary

CONGRESS OF THE UNITED STATES OFFICE OF TECHNOLOGY ASSESSMENT

Summary and Policy Options

INTRODUCTION

A nation's future lies with its children. Thus, the health of children is a matter of fundamental importance to all societies. In highly industrialized countries like the United States, the vast majority of children are healthy,[1] but preventing disease and reducing injuries among the young holds promise for even further improvements in their well-being.

Substantial improvements in children's health have been registered in the United States within the recent past. The U.S. infant mortality rate, for example, declined from 14.1 per 1,000 live births in 1977 to 10.8 in 1984, and the mortality rate of children between 1 and 14 years declined from 42.3 per 1,000 in 1977 to 34.1 per 1,000 in 1984.

Without dismissing the importance of such gains, one can cite at least three compelling reasons for an assessment of strategies for further improving American children's health. First, the evidence suggests that the United States is not doing as well as it could in preventing health problems in children, despite the improvements to date. Second, prevention or treatment of health care problems in early childhood can benefit a child for a lifetime, and, conversely, failure to prevent such problems can be costly to the child, the child's family, and the Nation. Finally, the burdens of illness, disability, and death are not borne evenly. Some American children are at particularly high risk for poor health, and many of them have only limited access to medical services.

Photo credit: March of Dimes Birth Defects Foundation

Prevention or treatment of health care problems in infancy or early childhood creates a lifetime of benefits for the child, the child's family, and society.

The high cost of poor health in infants and children suggests that some preventive strategies,[2] even those approaches that are initially expensive, may have payoffs in improved health, lower medical care costs, or both, that make them well worth their expense. The principal objective of this OTA assessment was to identify preventive strategies with high payoffs in relation to their initial costs.

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[1] As used in this assessment, health refers to physical, not emotional or mental health. As many as 12 to 15 percent of the Nation's children may suffer from mental or emotional problems. For a discussion of issues involving children's mental health, see OTA's background paper *Children's Mental Health: Problems and Services*.

[2] A preventive strategy is any action taken by individuals, professionals, or governments to alter the environment, change the behavior of a child or the family, or provide effective health care with the intention of preventing disease or injury. A strategy includes not only specific preventive technologies (e.g., vaccines or childproof safety caps for medicines) but also the means of financing, organizing, and delivering such technologies (e.g., mandatory school immunization programs).

STUDY BOUNDARIES

Given the wide range of potential issues in children's health, boundaries were needed for OTA's study. OTA focused on preventive strategies applicable to preadolescent children, because the major health problems of adolescence have their origins in emotional and behavioral problems rather than in problems of physical health.

Furthermore, the assessment focused largely on strategies involving personal health care services, not on strategies involving, for example, the educational sector or the larger environment in which children are raised. Some authorities claim that American children's health problems can be effectively addressed only in the context of a comprehensive national strategy that considers the implications of changes in the structure of the American family, the increasing percentage of mothers who work outside the home, and the increasing percentage of children in poverty. Although a good case can be made for a comprehensive national strategy on children, and some elements of such a strategy are already in place, there is still good reason to search for more limited actions that can be implemented and that can benefit children today.

This assessment of preventive strategies placed heavy emphasis on the importance of reducing the U.S. infant mortality rate, which is almost double the rate in Japan and higher than the rates in 15 other developed countries. One of the primary causes of infant mortality is low birthweight (under 2,500 grams or 5 lbs. 8 oz.). Two personal health care strategies for preventing low birthweight are examined in this assessment:

- providing better access to family planning services for high-risk women, particularly adolescents; and
- improving prenatal care for pregnant women at high risk of giving birth to low birthweight babies.

OTA also focused on four other health problems of young children:

- congenital disorders detectable by newborn screening techniques;
- diseases and conditions preventable through well-child care;
- accidental injuries; and
- maltreatment (child abuse and neglect).

Each of these health problems accounts for a substantial burden of illness, disability, and death in U.S. children. Table 1 summarizes some pertinent facts about each area chosen for study.

TRENDS IN U.S. INFANT MORTALITY

Infant mortality is a matter of widespread concern in this country. The infant mortality rate for any year is defined as the number of infant deaths under 1 year of age per 1,000 live births in the same year. **About 1 percent of all babies born in the United States—40,030 in 1985—die in the first year of life.** Almost two-thirds of these infant deaths occur in the neonatal period (the first 28 days of life); the others occur in the postneonatal period (28 days to 1 year).

The infant mortality rate has long been a primary indicator of the overall health status of nations for two reasons. First, it tends to be closely associated with access to food, shelter, education, sanitation, and health care; and second, it is relatively easy to monitor with basic vital statistics collected in most countries.

The United States ranks 17th among industrialized countries in infant mortality (see table 2), and its position has not improved since 1980 . If the U.S. infant mortality rate in 1985 had been equal to that achieved by the country with the lowest rate (Japan, with a rate of 5.5 deaths per 1,000 live births in 1985), there would have been 19,350 fewer infant deaths in the United States that year—a sum greater than the number of deaths of all U.S. children 1 to 15 years of age in 1985.

The high U.S. infant mortality rate is brought about largely by the high low birthweight rate in this country. Low birthweight so overwhelms

Table 1.—Burden of Illness in U.S. Children

Problem	Burden of illness or cost
Infant mortality and low birthweight	• Almost 40,000 babies (1 percent of all U.S. births) die in the first year of life each year. • The United States ranks 17th among industrialized countries in infant mortality. • 6.7 percent of all U.S. newborns are low birthweight babies (under 2,500 grams, about 5 lbs. 8 oz.). • 16 percent of all very low birthweight babies (i.e., those weighing under 1,500 grams, about 3 lbs. 5 oz.) are moderately or severely handicapped.
Congenital disorders detectable by newborn screening	• About 4,500 cases of detectable diseases causing death or mental retardation occur each year.
Conditions preventable through well-child care	• 37 percent of U.S. infants were fully immunized against diphtheria, tetanus, and pertussis (whooping cough) in 1983. • 78 percent of white children and 62 percent of nonwhite children from 1 to 4 years old were fully immunized against polio in 1985. • Almost 8,000 cases of measles occurred in the United States in 1986.
Accidental childhood injuries	• 7,850 deaths were caused by accidental injuries in children under 15 years old in 1984. • 1 in every 9 children is hospitalized for accidential or other injuries before age 15. • 10 million emergency room visits per year are made for accidental or other injuries.
Child maltreatment	• At least 1,200 children's deaths in 1986 occurred as a result of child abuse. • 24,000 children sustained serious physical injury due to child abuse in 1983. • 1.9 million cases of suspected child abuse and neglect were reported in 1985. • 150,000 to 200,000 cases of sexual abuse occur in the United States each year.

SOURCE: Office of Technology Assessment, 1988.

other health problems of early childhood that it cannot be ignored. The prevention of low birthweight and infant mortality has been a recent concern of many groups in this country; in 1979, the U.S. Surgeon General's Report on Health Promotion identified the reduction of infant mortality as a fundamental goal of the Nation.

Until the early 1980s, the United States made remarkable progress in reducing infant mortality. During the 17-year period from 1968 to 1985, the U.S. infant mortality rate declined by about 50 percent for both whites and blacks—from 21.8 deaths per 1,000 live births in 1968 to 10.6 per 1,000 births in 1985 (see figure 1). The average annual compound rate of decline during this period was 4.2 percent. The infant mortality rate for blacks remained equal to about twice the white rate throughout the 17-year period.

In the early 1980s, the pace of the decline in the U.S. infant mortality rate slowed appreciably. In the 3-year period from 1981 to 1984, the annual average of rate of decline was 3.3 percent, down by about 20 percent from the 4.1-percent average experienced in the 4-year period from 1977 to 1981. And **provisional U.S. infant mortality data extending into 1987 indicate continued deterioration in the pace of decline.**

Year-to-year fluctuations in reported infant mortality rates are to be expected, but the recent slowdown in improvement of the U.S. infant mortality rate cannot be dismissed as a random variation around the trend. At OTA's request, the National Center for Health Statistics (NCHS) predicted U.S. infant mortality rates for the 3-year period from 1982 to 1985 on the basis of trends in final U.S. infant mortality rates from 1968 to 1981. The U.S. infant mortality rate in 1985 was 10.6 infant deaths per 1,000 live births, significantly higher than the rate predicted for that year on the basis of the NCHS analysis (9.9 deaths per 1,000 births). Had the U.S. infant mortality rate

Table 2.—Comparison of Infant Mortality Rates[a] in the United States and Other Countries, 1985

Country	Infant mortality rate, 1985
1. Japan	5.5
2. Finland	6.3
3. Sweden	6.7
4. Switzerland	6.9
5. Denmark	7.9
6. Canada	7.9
7. Netherlands	8.0
8. France	8.1
9. Norway	8.3
10. Ireland	8.9
11. United Kingdom	9.4
12. Belgium	9.4
13. West Germany	9.5
14. East Germany	9.9
15. Australia	9.9
16. Spain	10.5[b]
17. United States	10.6
18. Italy	10.9
19. New Zealand	11.0
20. Austria	11.0
21. Israel	11.9
22. Brunei	12.0
23. Malta	13.6
24. Greece	14.0
25. Czechoslovakia	15.3[c]
26. Bulgaria	15.8
27. Cuba	16.5
28. Poland	18.5
29. Hungary	20.4
30. Romania	23.4[c]

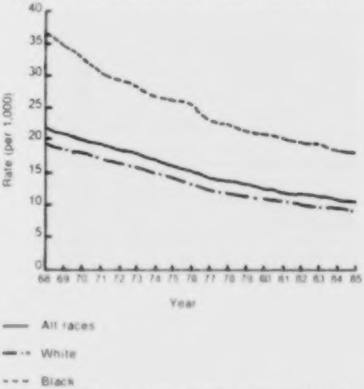
[a] The infant mortality rate is defined as the number of infants who die in the first year of life per 1,000 live births.

[b] This is Spain's infant mortality rate in 1983.

[c] These infant mortality rates are for 1984.

SOURCE: A. Von Cube, Population Reference Bureau, Washington, DC, personal communication, May and September 1987.

Figure 1.—U.S. Infant Mortality Rates by Race, 1968-85



SOURCE: Office of Technology Assessment, 1988, based on U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, Hyattsville, MD, unpublished data from U.S. vital statistics, 1988.

continued to decline after 1981 at the rate predicted by NCHS on the basis of previous trends, the United States would have suffered about 2,630 fewer infant deaths in 1985 than were actually reported.

No single explanation is sufficient for why the U.S. infant mortality rate began to level off in the early 1980s and continues to do so into the present. But **the key to the slowdown puzzle appears to be the deteriorating U.S. birthweight distribution—especially the increase in the number of live births recorded in the lowest birthweight categories.** In 1980, low birthweight infants represented less than 7 percent of all newborns in the United States but accounted for 60 percent of all babies who died in infancy.

Progress in reducing infant mortality rates can come through two routes:

1. changes in birthweight-specific infant mortality rates, and
2. changes in the distribution of birthweights toward heavier babies.

Historically, most of the progress in the United States since 1960 has been via the first route. In fact, between 1960 and 1980, about 91 percent of the improvement in the U.S. infant mortality rate was due to changes in birthweight-specific mortality rates. In recent years, U.S. birthweight-specific mortality rates have continued to improve, in large measure as a result of rapid advances in the technology of neonatal intensive care. Neonatal intensive care units (NICUs) offer sophisticated monitoring and therapy to premature infants whose undeveloped lungs do not function properly. The 1970s saw rapid advances in respiratory therapy techniques and improvements in mechanical ventilation, which had a major impact on the survival of premature infants with respiratory distress syndrome. In the 1980s, continued improvements in outcomes have occurred in very low birthweight infants (those under 1,500 grams or 3 lbs. 5 oz.), with the greatest improvement in the 750- to 1,000-gram birthweight group.

While U.S. birthweight-specific mortality rates have improved in the 1980s, the reported birthweight distribution in this country has actually deteriorated. Between 1977 and 1984, the percentage of live births at normal birthweights (greater than 2,500 grams) increased slightly, but the distribution of low birthweight infants shifted toward the lowest birthweight intervals (those under 1,000 grams or 2 lbs. 3 oz.). Had U.S. birthweight-specific mortality rates not improved in this period, the deteriorating birthweight distribution would have resulted in an *increase* in the overall U.S. infant mortality rate.

Ironically, the success of NICUs in improving outcomes of the larger very low birthweight babies may be partly responsible for the reported deterioration of the birthweight distribution. As the frontier of viability has been pushed back to smaller and smaller babies, obstetricians and neonatologists may be more frequently resuscitating the very tiniest newborns, even those under 500 grams, despite the fact that very few of these infants will survive. The increased concentration of high-risk births in sophisticated regional perinatal centers and ethical concerns arising from the "Baby Doe" controversy[3] may also be contributing to higher rates of resuscitation.

In addition to more aggressively resuscitating the tiniest newborns, U.S. hospitals today may be more careful to report as live births what in the past might have been reported as fetal deaths or have gone unreported altogether. Greater awareness of State birth reporting requirements and le[illegible] and economic considerations may be influencing reporting practices.

Whatever the reasons, the number of reported live births under 500 grams in this country increased much more rapidly in the 1980s than did live births at all other birthweights. The vast majority of newborns under 500 grams die in infancy; thus, an increase in the reported number of live births in this category would have the effect of pushing up U.S. infant mortality rates.

In fact, OTA calculated that if the number of live births under 500 grams had increased between 1977 and 1984 only as fast as the number in the other low birthweight categories, the U.S. infant mortality rate in 1984 would have been 10.4 rather than the reported rate of 10.8 per 1,000 live births.[4] The slowdown in the rate of change in U.S. infant mortality would have been much less apparent without the excess births in the under-500-gram category: the average annual rate of decline in U.S. infant mortality rate would have been 4.4 percent (rather than the reported rate of 4.1 percent) from 1977 to 1981 and 4.1 percent (rather than the reported rate of 3.3 percent) from 1981 to 1984. **Thus, a large part of the slowdown in improvement in the U.S. infant mortality rate in the early 1980s may be a reflection of changing management and reporting of very premature deliveries rather than a real deterioration in the health of pregnant women.**

Other factors may also have contributed to the slowdown in improvement, although available evidence suggests that their impact would be modest. Such factors include the natural maturation of technologies for neonatal intensive care that diffused widely in the mid-1970s and that are now improving outcomes of the smallest birthweight babies; the completion of the process of diffusion of abortion services in the late 1970s that may have differentially reduced birth rates in women at high risk for infant mortality, such as very young teenagers and unmarried women; the increase in the percentage of infants living in poverty; and deterioration in real dollars in the availability of subsidized health care services for pregnant women and children.

The coincidence of increasing poverty among infants in the early 1980s and decreased real spending on publicly subsidized health services in this country is particularly disturbing. From 1978 to 1984, the percentage of infants residing in poor families rose from about 18 to 24 percent.

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[3] Following the birth of Baby Jane Doe (an infant born with multiple birth defects) Federal regulations were written to require that hospitals treat severely handicapped infants over the objections of their parents. Those regulations were later declared unconstitutional by the Supreme Court.

[4] OTA assumed for this analysis that all under-500-gram live births died in infancy. Only a few such babies have survived to date.

During this period, Medicaid expenditures in constant dollars per child recipient declined by 13 percent and Federal funding for three important sources of primary health care for poor women and children—maternal and child health services, community health centers, and migrant health centers—declined in constant dollars by 32 percent.

Together, these trends suggest that **more pregnant women and infants encountered severe financial obstacles to obtaining timely health care services in the early 1980s than in the late 1970s.** Any resulting deprivation would be expected to have only a modest effect on the overall U.S. infant mortality rate, because relatively few women and infants would have been newly affected by the poverty and cutbacks and infant mortality is still a rare event. Yet, for a particular infant, being born to a mother in poverty with limited access to prenatal and infant care substantially raises the risk of dying in the first year. Thus, **cutting back on funding for health care services at the same time that infant poverty rates in this country were increasing raised the risks of infant mortality for these babies.**

PREVENTING LOW BIRTHWEIGHT

The United States invests a great deal in the treatment of low birthweight babies and realizes considerable success. Neonatal intensive care has played a major and definitive role in the improved survival of low birthweight and premature infants since its introduction in the 1960s.[5] Each year, about 150,000 to 200,000 infants (from 4 to 6 percent of all U.S. newborns) are admitted to NICUs. At least one-half of these infants are low birthweight babies. **Without question, neonatal intensive care is effective and becoming more effective over time.** In 1960, 72 percent of all very low birthweight infants (1,500 grams or less) born in hospitals with sophisticated NICUs died in the first 28 days of life; by the early 1970s, the percentage had dropped to 54, and by the early 1980s, it had declined to 27 percent.

Although NICU care is effective, it is also expensive, ranking among the most costly of all hospital care. The effort to reduce the dependence of low birthweight babies on this expensive technology adds urgency to the search for strategies to prevent the need for NICU care in the first place.

Prenatal Care

Prenatal care encompasses a wide range of preventive, diagnostic, and therapeutic services delivered throughout the course of pregnancy, with the goal of both a healthy baby and a healthy mother. Preventive components of prenatal care include screening for potentially harmful conditions in the mother and fetus, education and counseling, and sometimes nutritional supplements. Diagnostic and therapeutic interventions represent responses to and followup of problems identified either through symptoms or screening.

Photo credit: Yale University and March of Dimes Birth Defects Foundation

Questions remain about exactly which preventive measures in prenatal care are effective and at what intervals in the course of a normal pregnancy they are most effectively applied. Ultrasound examination is not currently recommended by the American College of Obstetricians and Gynecologists for routine use during pregnancy.

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[5] For detailed information on the effectiveness and costs of neonatal intensive care, see OTA's 1987 case study *Neonatal Intensive Care for Low Birthweight Infants: Costs and Effectiveness.*

Because prenatal care includes not only preventive interventions such as screening and counseling but also treatment when needed, it is bound to be effective in altering the health of some mothers and infants. Treatment of gestational diabetes or hemolytic disorders, for example, is critical to healthy outcomes for both mother and infant. The real question of effectiveness is not whether prenatal care makes any difference to child health, but exactly *which* preventive measures—monitoring, screening, education and counseling, or nutritional supplements—are effective and at what intervals in the course of a normal pregnancy they are most effectively applied.

Various new techniques of prenatal care are being developed, and evidence needs to be gathered to ensure their appropriate use in the care of pregnant women. One technique for which evidence is only now accumulating, for example, is called "ambulatory tocodynamometry." Its place in monitoring women at high risk for premature delivery is still undetermined.

Effectiveness

The earlier that prenatal care is initiated, the more frequent the number of scheduled visits, and the more screening procedures that are performed, the more expensive prenatal care becomes. If frequent routine visits and procedures do not offer any advantages in terms of lowering risks of premature labor, allowing more effective treatment or better management of labor and delivery than does seeking care when symptoms develop, the value of such preventive care would be dubious.

OTA examined the evidence on the effectiveness of early initiation of and more frequent prenatal care visits in reducing the rate of low birthweight and neonatal mortality. Despite serious shortcomings in almost all studies of prenatal care, **the weight of the evidence from more than 55 studies of the effectiveness of earlier, more frequent, or enriched prenatal care services supports the contention that two key birth outcomes—low birthweight and neonatal mortality—can be improved with earlier and more comprehensive prenatal care, especially in high-risk groups such as adolescents and poor women.** Although the evidence clearly supports the effectiveness of prenatal care, it is less revealing about the size of the effect that should be expected from increasing the quality or quantity of prenatal care received by any segment of the population.

Cost-Effectiveness of Expanded Prenatal Care for Poor Women

If prenatal care can improve birth outcomes, the logical next question is whether a specific strategy to increase access to effective services is worth its costs. The Omnibus Budget Reconciliation Act of 1986 (Public Law 99-509) gave States the authority to make a new group of previously ineligible pregnant women eligible for Medicaid—those whose incomes fall above the State's standards for Aid to Families With Dependent Children (AFDC) but below the Federal poverty level. Since April 1987, States have had the option of selecting any income standard for extending Medicaid eligibility to pregnant women, provided the standard is below the Federal poverty line.[6] By January 1988, 26 States had exercised their option to expand Medicaid eligibility to include more pregnant women in poverty.

OTA performed a cost-effectiveness analysis to determine how costs to the U.S. health care system (not just to Medicaid) would be affected by a policy of universal eligibility for Medicaid of all pregnant women in poverty. Under such a policy, approximately 194,000 pregnant women would be newly eligible for Medicaid coverage, but almost 60 percent of these women already have some form of private health insurance coverage. Overall, OTA estimated that offering Medicaid eligibility to all pregnant women in poverty would cause an additional 18.5 percent of women in this category to initiate early prenatal care (i.e., care in the first trimester of pregnancy). Nationally, the extra prenatal care would cost about $4 million per year.[7]

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[6] The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) passed by Congress in December 1987 (Public Law 100-203) gave States even greater freedom to expand eligibility for Medicaid to pregnant women with incomes up to 185 percent of the Federal poverty line.

[7] Note that these extra costs of prenatal care *do not* represent the additional costs to Medicaid of providing eligibility, nor do they represent the full costs of prenatal care for the newly eligible women. They represent the additional costs associated with the new care initiated as a result of enhanced eligibility. The extra costs to Medicaid might be much higher, since Medicaid would probably be paying for care that previously had been paid for by patients and their families or been donated by other government agencies, providers, or philanthropic groups.

OTA estimated that for every low birthweight birth averted by earlier or more frequent prenatal care, the U.S. health care system saves between $14,000 and $30,000 in newborn hospitalization, rehospitalizations in the first year, and long-term health care costs associated with low birthweight (see table 3).

How effective would earlier prenatal care have to be for the extra prenatal care costs among newly eligible women—estimated at $4 million—to be outweighed by the societal savings resulting from a reduction in the rate of low birthweight? **OTA estimated that the expansion of eligibility for prenatal care benefits under Medicaid would have to prevent between 133 and 286 low birthweight births among the 194,000 new eligibles for the societal health care savings to outweigh the costs.** If these women began with a low birthweight rate of 10.2 percent,[*] the low birthweight rate in the target population would have to decline by between 0.07 and 0.20 percentage points for health care costs to break even.

The reduction in low birthweight births would be concentrated in the group of poor women whose use of prenatal care changed as a result of the expanded eligibility for Medicaid. Among these new users, the low birthweight rate would have to decline by between 0.4 and 0.8 percentage points to between 9.4 and 9.8 percent.

Is it reasonable to expect reductions of this magnitude in the low birthweight rate? The evidence on the impact of earlier prenatal care on birthweight suggests that such reductions are quite feasible. The quantitative results of several reasonably well-designed studies of the effect of earlier prenatal care on birthweight showed effects that were at least twice as great as the effects required for the expansion of Medicaid eligibility to pay for itself in reduced health care costs. That early prenatal care can also be expected to prevent some infant deaths (though the number cannot be predicted with certainty) further enhances the strategy's cost-effectiveness. **Encouraging poor women to obtain early prenatal care through expanded Medicaid benefits is a good investment for the Nation.**

Table 3.—Net Incremental Health Care Costs of a Low Birthweight Birth

	Low-cost estimate	High-cost estimate
Initial hospitalization cost:		
• Hospital costs	$ 3,763	$ 5,236
• Physician costs	475	1,487
Total	$ 4,238	$ 6,723
Rehospitalization costs in first year (hospital costs only)	$ 802	$ 802
Long-term costs of treating low birthweight	$ 9,000	$23,000
Total net incremental costs	$14,040	$30,525

SOURCE: Office of Technology Assessment, 1988.

Comprehensive School-Based Clinics for Teenagers

One approach to reducing the U.S. infant mortality rate and low birthweight would be to give women at high risk of poor birth outcomes better opportunities to avoid unintended pregnancies. Teenagers and women age 35 and above have a higher risk than other women of having babies that die in the first 28 days of life and that weigh 2,500 grams (5 lbs. 8 oz.) or less at birth.[*] Similarly, women who have not graduated from high school are at greater risk of experiencing these poor birth outcomes than women with at least a high school education.

In 1984, over 1 million teenagers in the United States became pregnant. About 40 percent of these pregnancies ended in abortion and 13 percent ended in miscarriage, so the number of births to teenage mothers in this country in 1984 was about 470,000. The vast majority of teenage pregnancies are not only unintended but unwanted once they occur. In 1979, 82 percent of unmarried teenagers who became pregnant in the United States reported that the pregnancy was unwanted, but of unmarried teenagers who did not want their pregnancy, only 32 percent used contraception.

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[*] The low birthweight rate is defined as the percentage of live births with a birthweight of less than 2,500 grams.

[*] Except for very young teenagers (those under 15 years of age), the relationship between age and neonatal mortality is a reflection of other factors, such as poverty, poor health care, or risky behaviors, that tend to cluster in adolescent mothers.

Strategies for preventing teenage pregnancy span a wide range of philosophies, from programs that are intended to influence teenagers' attitudes about sexual behavior and relationships to programs that prescribe or dispense contraceptive services. There is tentative evidence that comprehensive school-based clinics that offer contraceptive services (as well as other kinds of health care) can lower teenage pregnancy rates and avoid unwanted births. Not all school-based clinics located in high schools and junior high schools offer family planning services. Of those that do, only a few actually dispense contraceptives. Some clinics prescribe contraceptives, and many others refer students to other providers.

The effectiveness of school-based clinics in preventing pregnancies and births among adolescents has been examined at two programs to date, one with three sites in St. Paul, Minnesota, and the other located in Baltimore, Maryland. Studies of the St. Paul school-based clinic program suggested that the program was successful in reducing birth rates among female students. The Baltimore school-based clinic program appears to have prevented pregnancies and reduced levels of sexual activity among students receiving services.

Although it is premature to draw conclusions about the effectiveness of school-based clinics in reducing high-risk unwanted pregnancies in adolescents, the evidence accumulated to date does look promising. The costs of providing comprehensive school-based health services is about $125 per year per student. As more evidence on the effectiveness of school-based clinics in reducing rates of teenage pregnancies and births accumulates, study of whether such clinics can yield net savings to the U.S. health care system will be warranted.

PREVENTING HEALTH PROBLEMS IN EARLY CHILDHOOD

Once a baby is born, various preventive strategies are available to promote his or her health during infancy and beyond. OTA assessed the effectiveness or cost-effectiveness of interventions in four general categories: newborn screening for congenital disorders, well-child care, prevention of accidental injuries, and prevention of child maltreatment.

Newborn Screening for Congenital Disorders

The screening of large populations of newborns for congenital disorders began as a public health activity in 1961 with screening for phenylketonuria (PKU). PKU, an inherited disorder of metabolism, occurs in about 1 in 10,000 to 1 in 15,000 infants. The development of a newborn screening test permitted its detection in the first week of life, so that treatment could begin before 2 to 4 weeks of age, thus avoiding the irreversible mental retardation that would otherwise occur.

Today, newborn screening for PKU and congenital hypothyroidism is conducted in all 50 States and the District of Columbia. Tests for various other congenital disorders are also offered in some States, including tests for homocystinuria, galactosemia, maple syrup urine disease, sickle-cell anemia, cystic fibrosis, biotinidase deficiency, and congenital adrenal hyperplasia.

In general, the disorders included in routine newborn screening programs are diseases that are present throughout the life of an affected individual, do not get better (and often worsen) with time, and can result in severe mental retardation, physical disabilities, and even sudden death if untreated in the first days or weeks after birth. Although only a few disorders are in this category and those are relatively rare, newborn screening followed by early and sustained treatment can make the crucial difference in affected infants.

Effectiveness

The effectiveness of newborn screening in identifying affected infants depends in part on the accuracy of the test itself; it also depends on the ability of the screening program to collect blood specimens from all infants and to perform the tests properly and in time to initiate treatment. Thus, the organization and management of newborn screening services, the timing and number of newborn blood specimens, and laboratory performance have major bearing on the effectiveness of newborn screening.

The United States and Canada are the only developed countries offering newborn screening that do not have a national screening program. In the absence of a national newborn screening program or national set of minimum standards, each State has taken a slightly different approach to providing screening services. A few States have joined with neighboring States to form regional programs. Most States have their own newborn screening programs; State programs usually do have a centralized screening laboratory, but many do not have an organized program of services linking the laboratory with followup, treatment, and monitoring. A few States operate without a central laboratory or a centrally organized program. These States rely on an informal network of individual families, physicians, and a combination of public and private laboratories to provide screening and followup.

In some areas, the lack of a coordinated network of newborn screening services may reduce the overall effectiveness of newborn screening by putting infants at risk for not being screened or for not receiving appropriate treatment. There are no national data on the number of infants at risk, however, because there is no central system for collecting comprehensive data with which to monitor and compare the outcomes of newborn screening in the State and regional programs.

Cost-Effectiveness of Newborn Screening

Although the value of newborn testing in the hospital for PKU and congenital hypothyroidism is now widely accepted, there is substantial question about the appropriateness of testing for other conditions and about the need for a routine second blood specimen at around the third week of life to pick up cases that might have been missed on the first screen. The second specimen issue has gained importance in recent years as the trend toward early hospital discharge of newborns has increased the probability that some affected infants will be missed. (In 1985, about 42 percent of all newborns were discharged before 3 days, up from 31 percent in 1980, and the optimal age for PKU testing is 3 to 5 days after birth.) Concern over the adequacy of the test in blood specimens taken within 24 hours of birth led the American Academy of Pediatrics (AAP) Committee on Genetics to recommend that all infants whose first sample was collected before 24 hours after birth have a second blood sample taken by the third week of life.

OTA performed a cost-effectiveness analysis comparing a basic screening strategy—one specimen taken in the hospital to test for PKU and congenital hypothyroidism—to no screening and to six expanded strategies. The six expanded strategies involve a second specimen or additional tests on a single specimen.

Newborn screening for PKU and congenital hypothyroidism using one specimen reflects the minimum situation common to all U.S. newborn screening programs. Compared to no screening, this basic screening strategy not only saves many infants (about 1,291 per year) from lifetimes of severe disability but also yields net savings for the U.S. health care system of about $120 million per year. **Each of the six expanded screening strategies would save more babies from deadly or disabling diseases than the basic strategy (ranging from 50 to 160 infants nationwide per year, depending on the strategy), but the incremental costs of achieving those extra successes are high** (see table 4).

The net health care costs per case detected by any of the expanded newborn screening strategies remain high even under the "best case" assumptions applied in a sensitivity analysis. OTA found, however, that under the best case assumptions, the cost of detecting an extra case via an expanded one-specimen strategy—to test for PKU, congenital hypothyroidism, galactosemia, and maple syrup urine disease—is about $85,000. This amount would buy an entire lifetime for a child with one of these disorders and is low compared to the cost of many therapies currently considered accepted medical procedure. The cost (in 1986 dollars) per year of life gained from heart transplantation for congestive heart failure, for example, is about $28,000 to $40,000, and for a year gained from hemodialysis for end-stage renal disease is about $36,500.

Table 4.—Incremental Effectiveness and Health Care Costs of Six Expanded Newborn Screening Strategies Compared to a Basic One-Specimen, Two-Test Strategy[a] (1986 dollars)

Expanded strategy	Number of extra cases detected in the United States	Net incremental cost per extra case detected and treated
Two specimens: on first specimen, test for PKU and CH; on second specimen, repeat test for PKU and CH in all infants	75	$466,000
Two specimens: on first specimen, test for PKU and CH; on second specimen, test for PKU and CH only in infants with first specimen collected less than 72 hours after birth	49	$253,000
Two specimens: on first specimen, test for PKU and CH; on second specimen, test for CH only in all infants	64	$432,000
Two specimens: on first specimen, test for PKU and CH; on second specimen, test for PKU, CH, and HC in all infants	94	$421,000
One specimen: test for PKU, CH, GA, and MSUD	68	$173,000
Two specimens: on first specimen, test for PKU, CH, GA, and MSUD; on second specimen, test for PKU, CH, and HC in all infants	162	$317,000

Abbreviations: PKU = phenylketonuria; CH = congenital hypothyroidism; HC = homocystinuria; GA = galactosemia; MSUD = maple syrup urine disease.

[a] The basic newborn screening strategy to which the expanded strategies in this table are compared is a one-specimen strategy with tests for phenylketonuria (PKU) and congenital hypothyroidism (CH).

SOURCE: Office of Technology Assessment, 1988.

Four congenital disorders not included in the screening strategies examined in OTA's cost-effectiveness analysis—sickle cell anemia, cystic fibrosis, biotinidase deficiency, and congenital adrenal hyperplasia—are being considered for inclusion in an increasing number of newborn screening programs. Newborn screening for sickle cell anemia, in particular, is gaining widespread support as a result of recent evidence linking early detection and treatment of the disease with reduced mortality in the first few years of life.

OTA did not evaluate tests for these four disorders in its cost-effectiveness analysis, because reliable data on the long-term value of screening for these disorders do not exist. Few evaluations of the sensitivity and specificity of the screening tests and of the long-term value of early detection and treatment of sickle cell anemia, cystic fibrosis, biotinidase deficiency, or congenital adrenal hyperplasia have been conducted. In the absence of more data on effectiveness, estimates of the cost of screening and treatment, not to mention costs averted by screening, would be incomplete at best.

Well-Child Care

Well-child care refers to a variety of preventive health services offered by physicians or other health professionals at defined points in a child's life, beginning as early as the second or third week after birth and extending into adulthood. The goal of well-child care is ultimately to improve the physical, cognitive, and psychological health of children both in childhood and adulthood.

Well-child care encompasses two main aspects of prevention:

- immunization; and
- health supervision, consisting of physical examinations and other tests that screen for illness or developmental problems, health education, and parental guidance.

Immunization

Immunization provides the starkest example of the power of prevention to save or prolong lives, prevent significant disability, and lower medical care costs. It represents the ideal of medical progress—prevention rather than cure or relief of symptoms. Today, children in the United States are routinely vaccinated against eight diseases: diphtheria, tetanus, pertussis (whooping cough), polio, measles, mumps, rubella (German measles), and, most recently, *Haemophilus influenzae b* (Hib).

The cost-effectiveness of the childhood vaccines is well established in the literature—indeed, such

Photo credit: Children's Hospital National Medical Center

Well-child care comprises physical examinations and tests that screen for illness or developmental problems, immunization against polio and other diseases, health education, and counseling of a child's parents.

vaccines not only confer medical benefits but are cost-saving. The diptheria, tetanus, and pertussis (DTP) vaccine—the most controversial vaccine—continues to be cost-saving, despite a rapid rise in vaccine prices due to the recent vaccine liability crises. As vaccine prices increase, however, costs saved with childhood immunization programs diminish. Thus, developments with regard to the current vaccine liability crisis will have an impact on whether childhood immunizations continue to be cost-saving.

New technologies on the horizon also will have an impact on the cost-effectiveness of childhood immunizations. Two new DTP vaccines developed by the U.S. National Institutes of Health and Japanese researchers could substantially reduce the number and seriousness of adverse reactions to the pertussis component of the DTP vaccine. A reduction in adverse reactions could decrease the amount of corresponding litigation and ultimately reduce vaccine prices.

Health Supervision

Evidence on the effectiveness of components of well-child care other than immunization is more remarkable for its limitations than for its findings. **No evidence supports the contention that well-child care other than immunization significantly influences mortality or morbidity among children or that it enhances the development of a child's social competence.** On the other hand, sample sizes have been uniformly too small and followup too brief to identify mortality changes; the available measures of childhood morbidity have been inadequate, and most investigators have not even looked at children's developmental outcomes. The particular importance of the outcome measures examined to date and their duration of impact have not been evaluated. For these reasons, expert opinion and good intentions rather than scientific data currently guide the provision of well-child care. **Participation in well-child care does seem to provide substantial satisfaction to both parents and providers, and the value of their satisfaction should not be overlooked.**

Of the components of well-child care examined by OTA, childhood immunization for eight diseases is the only one shown to be cost-effective and cost-saving. **A schedule of well-child care visits that corresponds to the AAP's and Immunization Practices Advisory Committee's recommended schedule for childhood immunization, therefore, is cost-saving.** Such a schedule would include seven well-child care visits for normal infants and children in the first 6 years of life. The schedule for well-child care visits recommended by AAP calls for 13 visits in the first 6 years of life. Whether more well-child care visits than the seven required for childhood immunizations would be cost-effective is unknown, because researchers have yet to be able to document the effectiveness of the health supervision aspects of well-child care in terms of improved health outcomes. In formulating recommended schedules for well-child care visits, AAP and other recommending bodies have relied on expert opinion regarding the effectiveness of the components of well-child care other than immunization.

Preventing Accidental Childhood Injuries

Accidental injuries are the leading cause of death in American children after the first few months of life.[10] In 1984, 7,850 U.S. children under age 15 died as a result of such injuries. Nationally, approximately 353,000 hospitalizations and nearly 10 million emergency treatments annually are due to childhood injuries. Approximately 4,700 children under age 17 experience bed-disabling injuries each year.

Childhood accidents are very costly to American society, even after the tremendous social and emotional costs of death and disability are excluded. NCHS estimated that in 1980, injuries and poisonings (accidental and nonaccidental) accounted for 13.3 percent of acute medical care costs for U.S. children under age 17, or nearly $2 billion. Most of this cost, which does not include long-term care costs or nonmedical costs, is probably due to accidental injuries. As a group, accidental and other injuries are the leading cause of potential years of life lost before age 65. In infants under age 1, injuries are the second leading cause of death (after death due to conditions present at birth); and in all other children under age 15, they are the leading cause of death.

In 1984, the greatest number (43 percent) of the accidental fatalities in children under age 15 resulted from vehicle-related accidents. Drowning and fires/burns were also prominent causes of death among children in this age group.

There are three broad strategies for preventing accidental childhood injuries:

- *Persuasion/education:* persuading people to increase their self-protection (e.g., through education or reminders to use seatbelts).
- *Regulation of behavior:* requiring people to increase their self-protection (e.g., by passing laws requiring the use of seatbelts).
- *Automatic protection:* providing automatic protection from injury through product or environmental design (e.g., by designing automobiles so that a person is automatically seatbelted when in the vehicle).

For motor-vehicle-related injuries in children, both regulation and automatic protection have been very effective in reducing deaths (and, presumably, serious injuries as well). In 1977, Tennessee passed the first State law requiring children to be restrained in an infant or child seat. By 1984, all 50 States had enacted laws requiring the use of safety restraints for children in automobiles. These laws contributed to the 36-percent decline in motor-vehicle occupant deaths among children under age 5 between 1980 and 1984.

Still, **there is considerable room for improving child safety restraint laws.** Many States require safety restraints in automobiles only for very young children. Altogether, 38 States have no restraint requirements for children over age 5 (and many States do not require restraints for children over 3 or 4). Laws covering only certain ages and exempting certain vehicles may fail to prevent a substantial number of avoidable deaths. One analysis of motor-vehicle occupant fatalities in very young children (ages 0 to 5) concluded that in some States, up to 43 percent of deaths occurred in children who would not have been covered under restraint laws as of 1984.

The evidence regarding the role of enforcement in improving the effectiveness of safety restraint use is somewhat conflicting. A few studies of specific enforcement efforts have found that such efforts had little additional effect. One study of seatbelt use found, however, that Texas had the highest rate of compliance in the Nation, a rate which Texas authorities attributed to vigorous enforcement efforts.

Automatic protection has also played an important role in the reduction of motor-vehicle-related childhood injuries. Attempts to reduce automobile injuries have included both product and environmental changes. The Motor Vehicle Safety Act of 1966 (Public Law 89-563) required automakers to include certain safety features in 1968 and subsequent model cars, such as shoulder belts, energy-absorbing steering assemblies, and interior padding. Reductions in automobile-associated deaths observed into the 1980s can probably be attributed in part to the continued attrition of old vehicles that did not meet the standards. The effect of the standards on death rates of children alone has not been estimated.

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[10] To describe accidental injuries, many people prefer the label "unintentional injuries" because they believe that the term "accidental" implies unavoidability. OTA has chosen to use the term accidental injuries for two reasons. One is that it is the term more commonly used by the general public. The other is that many researchers in the field of child abuse argue that the term unintentional injuries does not in fact exclude all injuries due to child abuse because some child abuse is unintentional.

Other possibilities for improvement also remain. For example, many vehicles still have protrusions such as knobs and tapered dashboards that can cause injury to the faces, heads, and chests of individuals during crashes or sudden braking. One study found that 12 percent of children's injuries in motor vehicles occurred in noncrash braking or swerving.

Although education programs designed to encourage families to use child safety restraints in automobiles have met with only modest success, education may be an important component of regulatory strategies, both in encouraging the legislative process and as a necessary background to acceptance and proper use of required technologies.

For accidental childhood injuries not involving motor vehicles, similar conclusions can be drawn. Automatic protection is most effective and regulation is often effective in reducing accidental injury rates, especially when accompanied by educational campaigns. Examples of actions that could together substantially reduce children's deaths due to accidental injuries include:

- helmets for bicyclists,
- barriers around swimming pools,
- universal use of smoke detectors,
- window bars in windows above the first floor,
- hot water heater temperatures of no more than 120 degrees Fahrenheit,
- stringent limits on the sales and use of all-terrain vehicles, and
- "no-right-turn-on-red" laws.

It must be remembered, however, that many of these preventive interventions involve additional costs to society or substantial loss of personal choice, issues that need to be taken into account when considering accident prevention policies.

Preventing Child Maltreatment

Child maltreatment—including physical, psychological, and sexual abuse and neglect—is an especially troubling children's health problem because it is caused primarily by adult behavior, not by accidents or natural disease processes. In the past two decades, there has been an explosion of concern in professional and lay communities about the problem, but policy debates regarding appropriate responses are hindered by the lack of consensus about what constitutes maltreatment, what causes it, how frequently it occurs, and, most important, how it can be prevented.

All 50 States and the District of Columbia have laws defining child maltreatment and mandating that professionals working with children report suspected cases. Typically these laws are vague, leaving a good deal open to interpretation. State child protection agencies, which are designated by law to respond to reports of alleged child maltreatment, typically have a higher threshold for identifying a case as abuse or neglect than health care professionals have. For example, a pediatrician might consider corporal punishment of a child to be abusive and decide to counsel a child's parents about alternative disciplinary strategies. A social worker for a State child protective service agency, on the other hand, might require scattered bruising to substantiate a case report.

The lack of clear definitions of child maltreatment complicates attempts to estimate the frequency with which maltreatment occurs, but even clear definitions would not make measurement of the size of the problem easy. The unacceptability of child maltreatment and its potential legal consequences makes conventional methods of estimating incidence and prevalence (e.g., population-based surveys or incident reporting) unreliable. The more serious the maltreatment, however, the more likely are reporting systems to identify incidents. In 1985, 1.9 million cases of child maltreatment were reported to child protective services agencies in the United States. A 1986 survey of child protection agencies estimated that at least 1,200 children died of child abuse in that year.

Few child maltreatment prevention programs have been rigorously evaluated to ascertain their short-term and long-term outcomes. Between 1979 and 1981, the National Center on Child Abuse and Neglect (NCCAN) sponsored a national evaluation by Berkeley Planning Associates of 19 NCCAN-funded clinical demonstration projects. The 19 federally funded projects were intended to demonstrate the effects of specialized clinical treatments in five abuse and neglect subpopulations (sexual abuse, adolescent maltreatment, substance-abuse-related maltreatment, child neglect, and remedial services to maltreated children). The evaluation methodology was critically flawed, lacking in comparison groups or in objective measures of effectiveness. Consequently, this evaluation provides little information regarding the usefulness of the approaches undertaken by the demonstration programs.

The use of home health visitors to families at high-risk for child maltreatment has been studied more than any other preventive approach. Five programs, each of which provided a wide array of services to clients including visits in the home, have been evaluated. Although the specific home care services differed among the studies, four of the five studies found that home care services were effective in reducing actual rates of child maltreatment.

Taken together, available evaluations of home health visitor programs suggest that such programs may be successful in preventing child abuse and neglect.[11] Although it is difficult to specify at this point what program elements are most important in producing the positive outcomes, the home visitor model appears to have a number of practical advantages that enhance its effectiveness, including reaching parents who lack self-confidence and trust in formal service providers, obtaining a more accurate and direct assessment of the home environment, linking parents with other support services, and reminding parents that excessive punishment or neglect of children are not condoned in our society.

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[11] Visiting nurses may also be effective in increasing birthweight and lowering infant mortality.

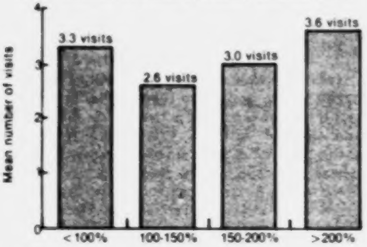
IMPROVING CHILDREN'S ACCESS TO EFFECTIVE HEALTH SERVICES

Although this assessment focused largely on preventive strategies for promoting or maintaining children's health, a fundamental question raised in any discussion of children's health is whether systematic differences exist in American children's access to needed health care services.

OTA's review of the available data revealed a consistent relationship between family income and children's use of health care services. Not surprisingly, the higher the family income, the more services a child uses. This relationship appears to be stronger the sicker the child. Very healthy children do not differ widely by income group—they all see physicians infrequently—but **the frequency with which American children who are sick see a physician depends very much on their income.**

The relationship between family income and children's use of health care services is softened by the availability of health insurance coverage, so that **very poor children, who have access to Medicaid, are more similar to middle-income children in the frequency of use of medical care than are other poor or low-income children** (see figure 2). Indeed, children on Medicaid appear to have as many general checkups and immunization visits as middle-income privately insured children (except for those enrolled in health maintenance organizations). As might be expected, **having a generous health insurance plan has a greater effect on the use of medical care for children in poverty than it does for other children.** Poor children whose families pay a large amount out of their own pockets use much less care than do those who receive free care. Parents do not appear to be particularly good at discriminating between visits that are likely to be highly effective and those that are not. When parents cut back on visits, they don't just cut back on care that is not likely to make much difference to the course

Figure 2.—U.S. Children's Medical Visits: Mean Number of Visits by Family Income, 1980



SOURCE: Office of Technology Assessment, 1988, based on data from J.A. Butler, W.D. Winter, J.D. Singer, et al., "Medical Care Use and Expenditure Among Children and Youth in the United States: Analysis of a National Probability Sample," *Pediatrics* 76(4):495-507, 1985.

of illness; they reduce in equal measure visits for conditions for which medical care is highly effective.

Family income and health insurance status influence not only the amount of health care U.S. children receive but also the site in which they receive it. **Poor children—both those with Medicaid eligibility and those without—are much more likely to receive care in a health clinic, a hospital emergency room, or outpatient department than are middle-income children.**

The result of these systematic differences in the frequency of use of services and the site of care suggests that poor children are treated very differently from nonpoor children by the U.S. health care system. **For poor children, the availability of adequate health insurance makes a big difference in whether they get care they need; however, Medicaid eligibility means that poor children are more likely to obtain medical care at a hospital or public clinic than in a private physician's practice.**

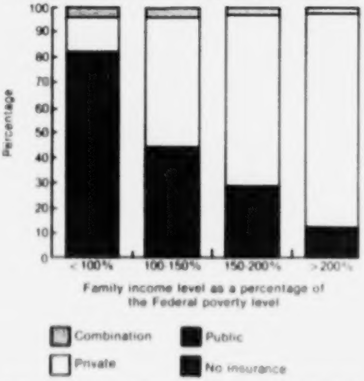
OTA estimates that in 1986, **between 14 and 19 percent of all American children under 13 years of age had no health insurance eligibility whatsoever.** These percentages translate to between 6.26 and 8.5 million children.

Children without health insurance are heavily concentrated among the poor and the near poor (family incomes between 100 and 150 percent of poverty) (see figure 3). In 1986, 61 percent of all children under age 13 who were reported to lack health insurance were from poor or near poor families.

Almost 40 percent of poor children in intact families have no health insurance. In fact, poor children in two-parent families are much less likely to have health insurance than are poor children living with never married mothers, whose rate of uninsuredness is at most 16 percent. This difference can be explained by the fact that children in intact families in poverty have somewhat higher incomes on average than do those in households headed by single mothers, making fewer of them eligible for Medicaid on the basis of income.

The existence of Medicaid is clearly a great benefit for eligible children. As a federally aided, State-administered program of medical assistance for low-income people, Medicaid enhances access

Figure 3.—Health Insurance Status of Children Under Age 13, by Income Level, United States, 1986[a]



[a]This figure is based on data from the Current Population Survey. Because that survey does not reflect insurance held by noncustodial parents, the percentage of children without health insurance—especially the percentage of children from higher income families—is probably overestimated.

SOURCE: Office of Technology Assessment, 1988, based on R. Swartz, Urban Institute, statistical analysis of the Bureau of the Census' Current Population Survey, 1986, prepared for the Office of Technology Assessment, U.S. Congress, Washington, DC, 1988.

to health care for the poor. Because each State designs and administers its own program within Federal guidelines, however, **the adequacy of Medicaid in meeting the needs of children varies widely across the States.**

Federal legislation has been expanding Medicaid eligibility for children since 1984. By July 1988, all children through age 6 who meet the income and resource requirements of the AFDC program, regardless of whether they are actually eligible for AFDC, will be eligible for Medicaid. Because the AFDC income standards are State-specific, however, the eligibility criteria are still varied and, in many States, stringent. **In 1986, less than one-half of all American children under 13 years of age in poverty were covered by Medicaid.**

The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) (Public Law 99-509) gave States the right to extend Medicaid on a phased-in basis to all children under 5 years of age whose incomes and resources put them below the Federal poverty line. As of January 1988, only 26 States had extended eligibility. More recently, the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) (Public Law 100-203) permitted States to offer Medicaid to infants whose family incomes are below 185 percent of the Federal poverty level and to children up through age 8 with family incomes below the poverty level.

Physicians who care for Medicaid patients encounter severe restrictions on the payments they receive. **In general, Medicaid fees lie well below the fees paid by Medicare, which are in turn lower than those paid by the private sector. The disparity grows with every year.** Between 1982 and 1984, for example, private physicians' fees increased by 13.2 percent, while the median Medicaid fee for a brief office visit remained virtually unchanged. **As a consequence of low Medicaid fees, physicians' willingness to participate in Medicaid is limited.** Nationally, pediatricians are about average among all specialties in their rates of participation, and their participation rates increased slightly in the period between 1978 and 1984. The increase may be due to factors unrelated to payment, in particular, the increase in the supply of pediatricians during the period. Despite these trends, continued stringency in Medicaid payment rates can only put more pressure on children's access to private physicians in the future.

Finally, **administrative red tape and payment delays not only slow down the Medicaid enrollment process but also discourage private providers from participating in the program.** The net result is that in many areas, children eligible for Medicaid must seek care at clinics that specialize in care for the indigent or at hospital emergency rooms.

CONCLUSIONS

Fortunately, most children in the United States enjoy excellent health, but this assessment demonstrates that greater strides toward improvement in their well-being are still possible if more emphasis is placed on cost-effective prevention strategies. As the same time, a reality must be recognized in any effort to employ such strategies. Every inch of ground gained is won with greater difficulty and usually at higher costs than the last because the remaining problems, by definition, are more intractable. It is the familiar phenomenon of diminishing returns, with one vital difference: virtually no new gain can be dismissed as unimportant if it promises some real reduction of infant mortality and other forms of suffering.

OPTIONS FOR FEDERAL POLICY

OTA has identified several preventive strategies for improving American children's health, some of which would be clearly cost-saving to the U.S. health care system, some of which are effective (though not cost-saving), and some of which hold promise of having important impacts on children's health:

- improved access to early prenatal care for poor women (cost-saving);
- comprehensive school-based clinics for adolescents at high risk of unwanted pregnancy (promising);
- newborn screening using a single blood specimen to identify four congenital disorders (PKU, congenital hypothyroidism, maple syrup urine disease, and galactosemia) (effective);
- well-child care as often as required for full immunization of young children (seven visits in first 6 years of life) (cost-saving);
- use of child safety restraints in automobiles (effective, probably cost-saving);
- nurse home visitor programs for pregnant women and infants in families potentially at high risk for low birthweight, childhood accidents, or child maltreatment (promising); and
- improved access to physicians' services for children living at or near the poverty level (effective).

Specific policies for bringing about these improvements are discussed below.

Expanding Access to Prenatal Care for Poor Women

Option 1: Congress could mandate that eligibility for Medicaid be extended to all pregnant women with incomes below the Federal poverty line.

In the Omnibus Budget Reconciliation Act passed in December 1987 (OBRA-87) (Public Law 100-203), Congress gave States the power to extend Medicaid coverage to pregnant women with family incomes up to 185 percent of the Federal poverty line.[12] States vary widely in Medicaid eligibility and benefit standards, however, and there is no reason to think that the variation will be reduced under a program in which participation is voluntary. So far, only 26 States have elected to expand Medicaid benefits to all pregnant women in poverty. States may be reluctant to undertake responsibility for a new eligibility group, because expanding Medicaid to pregnant women in poverty will increase Medicaid costs as Medicaid pays for prenatal care that formerly was paid for by other State programs with more Federal matching dollars (e.g., the Maternal and Child Health services block grant), paid for by the patients' families, or provided by physicians and hospitals without compensation.

Requiring Medicaid coverage of all women with incomes below the poverty line would ensure equity in eligibility for Medicaid across the States. This option would raise Medicaid costs, although it could free some Maternal and Child Health services (MCH) block grant money to be used for other health needs of children and pregnant women. In States reluctant to implement this option, its effectiveness could be undermined through enrollment procedures that delay or make difficult the determination of Medicaid eligibility.

Option 2: Congress could require States to shorten the period for determining Medicaid eligibility for pregnant women and could direct the Federal Medicaid authorities to promulgate simplified eligibility forms and procedures for such women.

In some States, pregnant women who are eligible for Medicaid find it difficult to receive early prenatal care because of delays in the Medicaid enrollment process. States have 45 days to process an application for Medicaid, but women may encounter additional delays when their applications are incomplete or when other problems arise. Congress could require States to make Medicaid eligibility determinations for pregnant women a priority and to require less documentation for approval.

Some providers have been reluctant to offer care to pregnant women in anticipation of their eligibility for Medicaid because of the fear of retroactive denial of eligibility and nonpayment for the services rendered. Under OBRA-86 (Public Law 99-509), a "qualified provider" can provide services to a woman presumed to be eligible and be guaranteed Medicaid reimbursement for that care even if eligibility is ultimately denied. Qual-

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[12] The 1987 Federal poverty level is $11,203 for a family of four.

Photo credit: March of Dimes Birth Defects Foundation

Early prenatal care can reduce the incidence of low birthweight and the high costs of neonatal intensive care

ified providers include health departments, hospitals, and clinics, but not private physicians' practices. Thus, the presumptive eligibility clause of OBRA-86 appears to channel pregnant women who are probably eligible for Medicaid into sources of prenatal care other than private physicians. Relaxing the definition of a "qualified provider" would assure private physicians of some Medicaid reimbursement even if a woman's eligibility for Medicaid is ultimately denied; thus, this change would encourage private physicians to accept poor women for prenatal care.

Encouraging the Development of Comprehensive School-Based Clinics for Adolescents

Option 3: The Federal Medicaid program could direct the States to expand funding for comprehensive school-based health clinics through Medicaid and its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

School-based health clinics that offer family planning services are promising as an effective way to reduce pregnancy rates among high-risk teenagers. Teenagers have special needs when it comes to family planning services. Because of their need for confidentiality, a caring attitude on the part of staff, and proximity, the usefulness of the existing network of family planning services for teenagers is limited.

At present, 64 percent of the total funding for school-based clinics is provided by public sources; the remaining 36 percent is provided by private sources (e.g., foundations, corporations, private fees). Of the public funding for school-based clinics, the bulk is provided by States through the MCH block grant or State-only funds. Medicaid's EPSDT program provides about 14 percent of the total funds for school-based clinics. Other Federal programs, including Title XX (Social Services), Title X (Family Planning), and the community health centers program, provide about 6 percent of the total funds.

As a comprehensive program of preventive care for Medicaid-eligible children under 21 years of age, EPSDT is potentially available to fund a greater proportion of the services provided by school-based clinics offering family planning services. In some States, however, school-based clinics are not recognized as Medicaid providers because they do not have a physician on staff. Furthermore, States can restrict payment to school-based clinics by stipulating very few screening visits for adolescents under the EPSDT periodicity schedule. To address these problems, Federal EPSDT regulations could be changed to require States to certify as EPSDT providers clinics that serve schools and to mandate a minimum number of EPSDT screening visits for adolescents.

Implementing this option would still leave to local jurisdictions the decisions about what kinds of services to provide and in what schools. This option would merely enable localities that want to offer family planning and other health services to high-risk adolescents through school-based clinics to make greater use of Medicaid funds.

Promoting Effective Newborn Screening Programs

Option 4: The Federal Government, acting through the Division of Maternal and Child Health, could use newborn screening grant funds to encourage States to develop coordinated newborn screening programs.

The effectiveness and costs of newborn screening depend on the accurate identification of infants with the target disorders and coordination of screening with followup and treatment services. Experts have long agreed that the quality and efficiency of newborn screening programs could be enhanced by the development of regional screening programs, particularly where small State populations and low budgets restrict access to high-quality screening services. Currently, however, there is no ongoing system in place to assist States in developing regional programs.

At present, there are only three regional newborn screening programs in the United States, together accounting for about 20 percent of births. A majority of births (about 71 percent) are covered by State screening programs, most of which have a centralized laboratory, but only some of which have an organized program of services linking the laboratory to followup, treatment, and monitoring. A few States, accounting for about 9 percent of all births, operate without either a central laboratory or a centrally organized program, thus relying on an informal network of families, physicians, and a combination of public and private laboratories to provide screening and followup. In some areas, the lack of a coordinated network of services may be putting infants at risk of not being screened or of not receiving appropriate treatment.

The importance of program organization and management in achieving the theoretically feasible levels of effectiveness and efficiency of newborn screening argues for an aggressive Federal posture in encouraging the development of high-quality, low-cost newborn screening programs.

The Centers for Disease Control's monitoring of the accuracy and precision of screening tests through its laboratory proficiency testing program addresses part, but not all, of the problem. The U.S. Department of Health and Human Services, acting through the Division of Maternal and Child Health in the Public Health Service, could take an active role in encouraging and coordinating the development of regionalized newborn screening programs through its already existing oversight authority and its discretionary funds.

Option 5: The Federal Government could increase funding for research on the effectiveness of newly developed tests designed for routine newborn screening.

A number of States are considering inclusion in their screening programs of newly developed tests for cystic fibrosis, sickle cell anemia, biotinidase deficiency, and congenital adrenal hyperplasia. Adequate funding of research on the effectiveness of screening and treatment for these four disorders before the new tests diffuse widely into routine screening is needed to ensure the appropriate use of resources.

The value of newborn screening for cystic fibrosis, the most common of the disorders currently under consideration for inclusion in screening programs, is currently unknown. Carefully designed research studies of both accuracy of detection and effectiveness of early treatment are needed to make good judgments about the appropriate place of tests for cystic fibrosis in newborn screening programs. One such study of cystic fibrosis, funded by the National Institutes of Health, is already underway.

A federally funded study of one aspect of early treatment for sickle cell anemia was recently conducted. That study found that the use of prophylactic antibiotics in affected infants was successful in reducing the risk of sudden death due to overwhelming infection early in life. Other issues in the screening and treatment aspects of newborn screening for sickle cell anemia have not yet been resolved. Such issues include problems in counseling and followup of sickle cell carriers.

Tests for biotinidase deficiency and congenital adrenal hyperplasia are already being included in many State screening programs. No adequate long-term studies to determine the value of screening for these two disorders have yet been done.

Encouraging Appropriate Well-Child Care

Option 6: The Federal Government could encourage States to develop EPSDT screening protocols that combine fewer well-child care visits than are recommended in the American Academy of Pediatrics (AAP) guidelines with real increases in physician fees.

For the poorest children who are eligible for Medicaid, access to well-child care needs to be dealt with either through the regular Medicaid

Photo credit: Children's Hospital National Medical Center

A schedule of well-child care visits that corresponds to the recommended schedule for childhood immunizations is both effective and cost-saving to the U.S. health care system.

program or through the Medicaid's EPSDT program. States have established EPSDT screening protocols that typically include fewer well-child visits than the 13 recommended in AAP guidelines but more than the 7 visits recommended for childhood immunizations in the first 6 years of life. But as the EPSDT program has been implemented by the States, only a minority of eligible Medicaid children actually do have EPSDT visits in any year.

There are several potential explanations for this situation. First, 32 States explicitly allow Medicaid providers to bill for routine checkups for children under the regular Medicaid program, so many children may be receiving well-child services through this source. Second, the EPSDT program in many States is not well integrated with the primary health care system; EPSDT screening sites are separate from children's usual sources of medical care. Third, States have not aggressively recruited providers to the EPSDT programs, and private providers may be reluctant to undertake the reporting commitments required by EPSDT. Finally, rates of payment for EPSDT screens are generally low.

To increase recruitment of providers to EPSDT, one of the key incentives is the level of payment offered by Medicaid for EPSDT services. The evidence supporting the provision of more well-child care visits than the number required for complete immunization is very limited. Thus, States could limit the number of well-child care visits under EPSDT to the seven required for immunizations and would be able to provide higher rates of payment to EPSDT providers without incurring additional program costs.

Whether this option would actually be cost-neutral to Medicaid programs is uncertain, because Medicaid children do not now receive the full complement of well-child care visits, and higher enrollments in EPSDT could actually increase the number of visits as well as the reimbursements per visit. Nevertheless, OTA's analysis indicates that improved adherence to clearly effective and cost-effective well-child care could be worth the immediate outlays.

Such a strategy would be counterproductive if only one part were implemented by the States. That is, if the States were to limit the EPSDT periodicity schedule without substantially increasing rates of payment for EPSDT screenings offered by private physicians, children might not receive the basic number of well-child care visits that are so clearly cost-saving to the U.S. health care system.

Reductions in the number of well-child care visits should not be confused with reductions in the scope and availability of followup services. Once problems are identified in Medicaid eligible children, the availability of diagnostic and treatment services is critical to these children's health status.

Option 7: Congress could require States to offer children required followup services identified in EPSDT screens, regardless of whether the services are covered in the State's Medicaid plan.

Once a child has entered the EPSDT screening system, the State is mandated to provide vision, hearing, and dental services but is not required to offer other followup care as needed above and beyond the services outlined in the State's Medicaid plan. This option would increase the probability that children's health problems identified by EPSDT screens are actually dealt with by Medicaid.

In States that contract with private providers for EPSDT screens, this option would encourage providers to enroll children in EPSDT. The option might discourage States from expanding Medicaid children's access to EPSDT services, however, because the State would lose control over covered services.

Encouraging the Use of Child Safety Restraints in Automobiles

Option 8: The Federal Government, operating through its highway funding authority, could encourage those States whose child safety restraint laws are not very stringent to adopt more rigorous standards.

Child motor-vehicle safety-restraint laws have indisputably reduced serious injuries in very young children, and all States currently have laws requiring the use of infant or child restraints. The details of these State laws differ. To enhance the safety of children in States with less effective laws, the Federal Government could promulgate a model child safety restraint law whose adoption could be required for the receipt of Federal highway funds.

Encouraging the Development of Nurse Home Visitor Programs

Option 9: Congress could mandate that the U.S. Department of Health and Human Services fund experiments and evaluations of home visitor programs in populations at high risk for low birthweight or child maltreatment and other injuries.

Home visitor programs are labor-intensive and therefore costly, and the evidence on their effectiveness is based on a small number of programs run by dedicated, enthusiastic, and particularly skilled people, so it is premature to conclude that the home visitor approach should be broadly applied. Nevertheless, the evidence is certainly strong enough to warrant more widespread experimentation with the home visitor concept as a method of improving the outcome of pregnancy and the health of young children. Possible funding and coordinating agencies include the National Center on Child Abuse and Neglect (NCCAN), the Division of Maternal and Child Health in the Public Health Service, and the Centers for Disease Control, all of which have jurisdiction over child health problems for which home visitor programs may be effective.

Funding for experimental programs needs to be directed to those with the strongest evaluation designs if useful information on effectiveness is to be achieved. The performance of NCCAN in funding valid research has been disappointing. Peer review of proposals for demonstration and evaluation grants or contracts is one way of directing funds to the programs with the strongest evaluation designs.

The U.S. Department of Health and Human Services already has the power to issue waivers under the Medicaid program to States that offer additional services (such as home visitors) to selected subgroups of Medicaid eligibles as an inducement to participate in case-management systems where the freedom to choose a provider is restricted (Sec. 1915(b) of the Social Security Act). To obtain a waiver, however, a State must show that the proposed program will as a whole reduce costs or slow the rate of increase in Medicaid program costs. It may be difficult to justify an expensive program such as home visitors on the basis of cost-savings to Medicaid. More flexibility on the part of the Health Care Financing Administration in approving waivers containing these services would enhance the development of such programs.

Improving Poor Children's Access to Physicians' Care

Option 10: Congress could mandate that eligibility for Medicaid be extended to all children under 9 years of age in families with incomes below the Federal poverty line.

OBRA-87 gave States the option to expand Medicaid to cover all poor children under 9 years of age and infants in families with incomes up to 185 percent of the Federal poverty line. Making Medicaid eligibility for all poor children under age 9 mandatory would eliminate the inevitable disparity among States in eligibility that will result from the optional provisions of OBRA-87 and would improve access to care for such children.

The available evidence suggests that this option would be likely to improve the health status of newly eligible Medicaid children because it would increase their use of effective health care. It would also be costly to Medicaid because free care would bring about more use of medical care by these children.

Option 11: Congress could require States to increase the fees paid to physicians when they care for Medicaid children.

For children who are eligible, the Medicaid program offers a comprehensive array of health services. The key problem, however, is finding adequate sources of care. Physician participation in the Medicaid program varies from place to place, but it is clear that there are administrative and payment barriers that discourage Medicaid families from using private practices.

The low levels of Medicaid fees in comparison to private fees in many States is of particular concern. By mandating increased fee levels for physicians who treat Medicaid children, Congress could arrest the tendency for Medicaid children to seek primary care in sites different from those used by non-Medicaid children. Increased fee levels would also raise Medicaid program costs, however, and could encourage some unnecessary use of health services by Medicaid patients.

Option 12: Congress could increase direct Federal subsidies of health care providers—through community health centers, maternal and child health projects, and other programs administered by State and local governments—to provide primary health care for poor families.

An alternative to expanding Medicaid eligibility would be for the Federal Government to increase its commitment to funding publicly subsidized providers of health care for the poor. The erosion of real Federal funding of programs that provide health care services for poor children and pregnant women in the last 9 years—a period when the population of poor and uninsured children grew—has caused an increasing strain on these services.

Increasing funding for direct provision of health services to the poor would have the advantage of permitting States or localities to target services to areas of greatest need and to tailor programs to the needs of poor women and children. Programs of enriched prenatal care, for example, can be more easily coordinated through State or local governments or community health centers than through physicians' private practices.

By definition, however, the funding of public or publicly subsidized clinics for the poor tends to separate provision of care for poor children and pregnant women from care given to the nonpoor. The implications of separate streams of medical care are unclear. Although targeted programs can offer enhanced services tailored to the multiple needs of poor children and their families, their quality and effectiveness are likely to vary widely across areas. Without freedom to use other settings of care made possible by access to public or private health insurance, some poor women and children could ultimately receive lower quality care.

NOTE: Copies of the report "Healthy Children: Investing in the Future" can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325, GPO stock No. 052-003-01081-0; $13.00.

MATERNAL, CHILD HEALTH, AND FAMILY PLANNING SERVICES

Title X of the Public Health Service Act

FRIDAY, APRIL 22, 1988

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Health and the Environment,
Washington, DC.

The subcommittee met pursuant to call at 9:45 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. **Waxman**. The meeting of the subcommittee will come to order.

Today's hearing is on the reauthorization of the Federal Family Planning Program, also known as title X of the Public Health Service Act. Along with Congressman Madigan, I have introduced legislation to extend that program for 3 years.

As anyone who reads a newspaper or a law review knows, this program has been attacked from almost the first moment of the present administration. Overlooking the medical, public health, and health care benefits of contraception, the administration has sought to defund the program, harass its providers and its patients, relocate its services, and revise the basic statute by regulation.

In Congress, in the courts, and in the clinics, none of these efforts has succeeded, and none of them has diminished the widespread public and political support that exists throughout the Nation for the Family Planning Program. Americans of all stripe—Republican and Democrat, Liberal and Conservative, anti-abortion and prochoice—support title X. They recognize that it promotes maternal and child health and family stability. They recognize that for every dollar invested in family planning, we save $3 in health care costs. They recognize that with adequate counseling and contraception, the need for abortion services diminishes.

There has been confusion. Both inside and outside the administration, efforts have been made to make title X a litmus test for abortion politics. These efforts are mistaken and misguided, and ultimately have fooled very few people for only a short time.

I know that these efforts are ongoing, but this year I hope that the Congress will recognize that title X and family planning services in general are solid health care. Along with childhood immunizations, family planning is probably the most direct and effective method we have for preventing illness and for limiting health care costs.

I hope that today's hearing will demonstrate this effectiveness and lead to the reauthorization of this successful program.

I would like to ask unanimous consent that the Waxman-Madigan bill, H.R. 3769 be part of the record at this point.

[The text of H.R. 3769 follows:]

100TH CONGRESS
1ST SESSION

H. R. 3769

To amend the Public Health Service Act to revise and extend the program of assistance for family planning services.

IN THE HOUSE OF REPRESENTATIVES

DECEMBER 15, 1987

Mr. WAXMAN (for himself and Mr. MADIGAN) introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Public Health Service Act to revise and extend the program of assistance for family planning services.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Family Planning Amendments Act of 1987".

SEC. 2. PROJECT GRANTS AND CONTRACTS FOR FAMILY PLANNING SERVICES.

Section 1001 of the Public Health Service Act (42 U.S.C. 300) is amended—

(1) by striking subsection (c) and redesignating subsection (d) as subsection (c); and

(2) by amending subsection (c) (as so redesignated) to read as follows:

"(c) For the purpose of grants and contracts under subsection (a), there are authorized to be appropriated $148,300,000 for fiscal year 1989, $156,200,000 for fiscal year 1990, and $164,200,000 for fiscal year 1991.".

SEC. 3. FORMULA GRANTS TO STATES FOR FAMILY PLANNING SERVICES.

Title X of the Public Health Service Act (42 U.S.C. 300 et seq.) is amended—

(1) by striking section 1002;

(2) by striking "or 1002" in section 1006(c); and

(3) by redesignating section 1003 as section 1002.

SEC. 4. TRAINING GRANTS AND CONTRACTS.

(a) IN GENERAL.—Section 1002(a) of the Public Health Service Act (as redesignated in section 3(3) of this Act) is amended by striking "to provide" and all that follows and inserting the following: "to provide technical assistance and clinical training for personnel (including obstetric-gynecologic nurse practitioners), training for educators and counselors, and training of other personnel to carry out family planning service programs described in sections 1001 and 1005.".

(b) AUTHORIZATIONS OF APPROPRIATIONS.—Section 1002(b) of the Public Health Service Act (as redesignated in section 3(3) of this Act) is amended to read as follows:

"(b) For the purpose of grants and contracts under subsection (a), there are authorized to be appropriated $4,700,000 for fiscal year 1989, $4,900,000 for fiscal year 1990, and $5,100,000 for fiscal year 1991.".

SEC. 5. ESTABLISHMENT OF GRANT PROGRAM WITH RESPECT TO CONTRACEPTION.

Title X of the Public Health Service Act (42 U.S.C. 300 et seq.) is amended by inserting before section 1004 the following new section:

"CONTRACEPTIVE DEVELOPMENT AND EVALUATION

"SEC. 1003. (a) The Secretary may—

"(1) conduct, and

"(2) make grants to public and nonprofit private entities and enter into contracts with public and private entities and individuals for,

research into the development of new or improved contraceptive devices, drugs, and techniques and evaluations of the acceptance, convenience, safety, efficacy, and cost of contraceptive devices, drugs, and techniques.

"(b) For the purpose of carrying out subsection (a), there are authorized to be appropriated such sums as may be necessary.".

SEC. 6. RESEARCH.

Section 1004 of the Public Health Service Act (42 U.S.C. 300a-2) is amended in the matter after and below paragraph (2)—

(1) by striking "development," and inserting "development and evaluation,"; and

(2) by striking "population." and inserting the following: "population, and research to improve the clinical management and direct delivery of family planning services.".

SEC. 7. ESTABLISHMENT OF GRANT PROGRAM WITH RESPECT TO INFORMATION AND EDUCATION.

Section 1005 of the Public Health Service Act (42 U.S.C. 300a-3) is amended to read as follows:

"INFORMATION AND EDUCATION

"SEC. 1005. (a) The Secretary may make grants to public and nonprofit private entities and enter into contracts with public and private entities to assist in making available information and education to enable persons to make responsible choices concerning human sexuality, pregnancy, and parenthood. Such information and education shall be made available to all persons desiring it, either through appropriate community organizations or through facilities of the Department of Health and Human Services, with special emphasis on adolescents and parents, and shall include information about the availability of family planning methods and services.

"(b) For the purpose of grants and contracts under subsection (a), there are authorized to be appropriated such sums as may be necessary.".

SEC. 8. ESTABLISHMENT OF REQUIREMENT OF COLLECTION OF CERTAIN DATA.

(a) IN GENERAL.—Title X of the Public Health Service Act (42 U.S.C. 300 et seq.) is amended by adding at the end the following:

"DATA COLLECTION

"SEC. 1010. (a) The Secretary shall, on an annual basis, collect data on—

"(1) the number of individuals who receive family planning services from entities that receive grants under section 1001 and the age, sex, race, and family income of each of such individuals;

"(2) the types of family planning services chosen by individuals who receive services from entities that receive grants under section 1001;

"(3) the number of low-income individuals, marginal-income individuals, and teenagers, at risk of unintended pregnancies; and

"(4) the sources of funding for subsidized family planning services in the United States.

"(b) The Secretary may carry out subsection (a) through grants to public and nonprofit private entities and through contracts with public and private entities and individuals.

"(c) The Secretary shall make data collected under subsection (a) available to the public.".

(b) CONFORMING AMENDMENT.—Section 1009(a) of the Public Health Service Act (42 U.S.C. 300a-6a(a)) is amended in the matter preceding paragraph (1) by striking "plan" and all that follows and inserting the following: "plan, to be based upon data collected under section 1010 and carried out over the next five fiscal years, for—".

SEC. 9. EFFECTIVE DATE.

The amendments made by this Act shall take effect October 1, 1988, or upon the date of the enactment of this Act, whichever occurs later.

Mr. Waxman. Before calling forth our witnesses, I would like to call upon a very distinguished member of the Energy and Commerce Committee, Congressman Nielson, from the State of Utah, for comments you may wish to make.

Mr. Nielson. I am not a member of this subcommittee. I was for two terms. I am a member of the full committee. I appreciate the chairman allowing me to sit on the panel. I have a real interest in this particular title, title X and title XX.

At one time we made a little agreement we won't mess with title X if you don't mess with title XX. We do have some interest in the area. I have a witness who will be speaking on the third panel, Dr. Stan Weed, who has done a lot of work on teenaged pregnancy. I will be introducing him at that time.

I appreciate the chairman's willingness to let me sit on the panel. I hope I can be helpful.

Mr. Waxman. We are pleased to have with us representing the administration, the Assistant Secretary for Health, Department of Health and Human Services, Dr. Robert E. Windom. We want to welcome you to our subcommittee hearing this morning.

We have your prepared statement. We will make it part of the record in full. We would like you to summarize or make your oral presentation to us in around 5 minutes so we will have a full opportunity for questions and answers.

STATEMENT OF ROBERT E. WINDOM, ASSISTANT SECRETARY FOR HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, ACCOMPANIED BY NABERS CABANISS, DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS; AND RONALD ROBERTSON, GENERAL COUNSEL

Mr. Windom. I am pleased to be here today to discuss title X of the Public Health Service Act, the Family Planning Program. Accompanying me is Miss Nabers Cabaniss, Deputy Assistant Secretary for Population Affairs who is directly responsible for administering the program and Mr. Ronald Robertson, General Counsel for the Department of Health and Human Services.

Family planning services are an integral component of primary health care and are well established in most States. The Department strongly supports authorization of the title X family planning program as a State-administered grant program and will soon submit legislation to bring this change about.

Making the States the sole family planning grantees will enable them to exercise maximum flexibility in tailoring services to best meet their citizens' needs. States and territorial health departments are the sole grantees in 33 States and territories, and in another 11 States they are one of the grantees funded by the program. Passage of our proposal would allow States to administer the Family Planning Program in all jurisdictions, with the flexibility to operate clinics through county agencies, private agencies, or hospitals as is most appropriate for each particular State.

In my testimony today I would like to discuss the current categorical family planning program under title X of the Public Health Service Act, provide more detail on our proposal to transfer the administration of the program to the States, and discuss several key activities and priorities of the program under its current form.

The current title X family planning statute authorizes four components: family planning services, research, training, and information and education. In fiscal year 1988, $130 million was provided to support family planning services. In addition to the services funds, estimated funding for the three other major program areas is $1.4 million to support the research program designed to improve the delivery of family planning services, $3.4 million to provide training for family planning personnel, and $400,000 to fund information and education activities.

Title X was enacted in 1970 as a national program to assist in making "family planning services readily available to all persons desiring such services." Family planning projects are required to provide a broad range of acceptable and effective methods of contraception and various other services related to reproductive health care. Acceptance of family planning services must be voluntary.

Since the enactment of title X, requirements have been added that natural family planning, infertility services, services for adolescents, and family involvement must be a part of title X projects. In accordance with the statute, programs funded by title X must assure that priority is given to persons from low-income families.

Title X contains an explicit prohibition on use of funds appropriated under this title in programs where abortion is a method of family planning. Recently, the Department promulgated new regulations to ensure grantee compliance with this prohibition.

To support the delivery of family planning services, grants are awarded to public and private nonprofit entities to establish and operate voluntary family planning projects. These grants are awarded and monitored by the Public Health Service regional offices.

In fiscal year 1987, $136 million was spent to fund 89 grantees that provided services at over 4,000 clinic sites to an estimated 4.3 million persons—about one-third of whom were adolescents. In fiscal year 1988, as a result of the bipartisan budget agreement to reduce the deficit, $130 million has been made available to approximately the same number of grantees and clinics to support services.

In addition to the fiscal year 1988 funds provided to each regional office in accordance with the allocation, $478,000 has been provided to each region to support national priority projects in the areas of infertility services, family involvement, male involvement, adolescent abstinence, prevention of sexually transmitted diseases, and regionally determined areas of concern.

The focus of the Service Delivery Improvement [SDI] Research Program continues to be the enhancement of the delivery system, particularly at the clinic level. Six service delivery improvement projects are currently funded, including projects to study the effects of integrating family planning services with other services, the factors influencing contraceptive behavior among adolescent clients, and ways in which clinics can attract more male clients.

An agreement has been continued between the Office Population Affairs and the National Institutes of Health [NIH] to provide peer review of all service delivery improvement research grant applications. This process insures the selection of projects which are of high technical quality and are directed to high priority research questions within the family planning field.

To ensure that service providers, researchers, and policymakers have access to the research findings, all SDI research grantees are required to deposit their data in a public use data archive. This facilitates not only wide availability of the study results, but also ensures that the data upon which the conclusions were based is accessible. Findings from recently completed projects are being published in such journals as "Family Planning Perspectives" and "American Journal of Public Health."

Title X training programs are designed to provide personnel with skills and knowledge necessary for the effective delivery of family planning services. Training is currently provided through 10 regional general training grants and 5 nurse practitioner training grants. These grants provide training for personnel at all levels of services delivery including medical and professional staff, administrators, and technical and clerical staff.

In fiscal year 1988, each of the training grantees were awarded supplemental funds to provide training on the prevention of AIDS. Support is also continuing for the development of a broad range of family planning information and educational materials to be made available to all persons desiring them. Under the law, informational and educational materials used in title X projects must be suitable for the community and population for which they are used.

We will very shortly be submitting legislation to establish title X as a family planning grant program fully administered by the States. Shifting the administration of the family planning grant program to the States will enable them to exercise maximum flexibility in tailoring services to more appropriately and effectively meet their citizens' family planning needs. Within this framework, certain Federal requirements would be retained from current law, including the prohibition on funding programs where abortion is a method of family planning, the priority for serving low income families, the encouragement of family participation, and the requirement that services be voluntary.

The proposed program of State-administered grants would have many advantages over the present grant program. It would result in improved allocation of resources, improved services delivery, and greater administrative flexibility. This proposal will allow States to plan family planning programs in conjunction with other State-administered health programs. Service delivery and program administration would also be improved by elimination of burdensome application, reporting, and monitoring requirements in the current program.

I would now like to report on two current issues in family planning which I believe will be of interest to the committee: the new title X regulations and title X policy with regard to AIDS.

As you know, on February 2, the Department of Health and Human Services issued final regulations to clarify and enforce the statutory prohibition on use of funds in programs where abortion is a method of method planning. Implementation of these regulations has been enjoined by court action in Boston, Denver, and New York. Pending clarification of the scope of the permanent injunction in Boston, the HHS regional offices have been instructed to refrain from implementing the final rules.

Although efforts to prevent HIV infection have generally focused on homosexual and drug abuse populations, we must not overlook the critical role of the family planning program to prevent heterosexual and perinatal transmission. Last year, the Office of Population Affairs issued program guidance which requires all family planning clinics to offer, at a minimum, (1) education on HIV infection and AIDS, (2) counseling on risks and infection prevention, and (3) referral to other facilities when appropriate for further evaluation or services. This program instruction makes clear that, as appropriate, family planning clinics may provide and pay for prevention services such as behavioral risk assessment, HIV testing and pre- and post-test counseling.

The title X Family Planning Program plays an important role in the health care system by providing a needed service to over 4 million persons, primarily low-income women, each year. We believe our proposal to shift administration of the program to the States will provide States with the necessary authority and flexibility to improve the efficiency and effectiveness of the program. This action will increase the program's ability to meet the health care needs of our citizens and improve the delivery of high quality, free or low-cost family planning services to the people who need these services.

Mr. Chairman, we urge you and your colleagues to join with the administration in supporting our legislation to facilitate the delivery of improved and better coordinated family planning services within the State-administered Family Planning Program.

Mr. **Waxman**. Thank you, Dr. Windom, for your testimony. In 1984, Secretary Heckler testified before this committee that the inspector general of HHS had determined that "the prohibition against abortion was well-known at the level of the family planning clinics, and it was being honored." She went on to say that "the family planning clinics have been very aware and have honored the law in terms of the abortion prohibition which was the main subject of the GAO report."

In 1985, the last time this committee held hearings on the title X program, Dr. James Mason, who was then in your job, testified on behalf of the administration. I asked Dr. Mason at that time if he agreed with the 1984 statement made by Secretary Heckler. He responded, "Yes, I agree with the Secretary."

In his confirmation testimony, Secretary Bowen said he "saw no reason to change Secretary Heckler's assessment."

My first question to you, Dr. Windom, is simply this: Do you agree with Secretary Heckler, Dr. Mason, and Secretary Bowen?

Mr. **Windom**. Mr. Chairman, I would like to clarify the answer to that question, but Ms. Cabaniss will respond because it is in the testimony.

Mr. **Waxman**. I am asking you the question. They testified that the prohibition against abortion was well known at the level of family planning clinics, and it was being honored. You are now testifying on behalf of the administration. Do you agree with Secretary Heckler and Secretary Bowen and Dr. Mason?

Mr. WINDOM. I think from what our testimony showed from Ms. Heckler at that time, there was confusion on her part about that. It was not clear as to what was really the intention of her statement. That is why I wanted to refer to——

Mr. WAXMAN. Let me ask about the present status. Do you believe at the present time that the family planning clinics are aware of the prohibition against abortion and that they are honoring the law prohibiting family planning clinics from engaging in abortion? I am asking Dr. Windom that question.

Mr. WINDOM. Well, they are honoring what is currently believed to be the direction that they are to follow. However, I believe there is some misunderstanding that is there that creates the problem.

Mr. WAXMAN. What is that misunderstanding?

Mr. WINDOM. Well, may I refer to this testimony that was—that you are referring to also and read it? When that question was asked, Ms. Heckler said, "I certainly do not." I have always known the difference, obviously, if a statute prohibits abortion advice, counseling or involvement. I will say that I think Marge Mechlinberg was appointed and works under Dr. Gramm, who is a very able assistant.

Unfortunately the whole area of population affairs and family planning throughout history we have seen almost a political saw on one side of the issue or the other.

Mr. WAXMAN. Whose testimony is this?

Mr. WINDOM. Ms. Heckler's testimony that you are referring to her statement back in 19——

Mr. WAXMAN. She told us at that time she saw no reason to change the law. Dr. Bowen indicated to us he saw no reason to change the law. I am asking you, since you are in charge of running the Department as it relates to health issues. We have a law that says family planning clinics are not to be engaging in abortion services, and I wanted to know from you whether you think that the family planning clinics are aware of this prohibition against abortion services and are honoring the law that requires them to refrain from those services?

Mr. WINDOM. That is why, I would say, sir, that at this point we feel there is confusion in the area and that is why we have promulgated the new regulations to clarify that. So your answer directly, there does not exist in all these clinic sites that clear understanding of the law, and where this is a site of confusion, we feel the law needs or the regulations need to be more specific.

Mr. WAXMAN. Well, GAO—the Government Accounting Office—conducted a study in 1982 on this issue. That was 6 years ago. They found in their evaluation that the family planning clinics were very much aware and were honoring the law in terms of the abortion prohibition.

Now, you feel either that the GAO finding wasn't correct, that is, that the clinics are not honoring the law, or, two, that you don't think that it is clear that there is a prohibition against abortion services. Which is it?

Mr. WINDOM. I think the law from the GAO report indicated that we need to clarify the scope of the law. That is why we are following in that direction, to make it more specific and clear. Because there was existing some confusion at that time, too.

That report asked us in the Department to clarify the entire scope of that.

Mr. **Waxman**. Under the authority of the Department by regulations, you have sought to change the law and three courts have said that those regulations are illegal. I want to ask you this: What evidence do you have which indicates that family planning clinics either were unaware that the law prohibited them from doing abortion services, or were not following the law?

Mr. **Windom**. I think the clarity of the fact that the people in the clinics understood that they could not perform abortions, they still were not clear of the scope of what was allowed for them to do in regard to the abortion issue.

That is why we are trying to clarify that, to make it clear for all to understand.

Mr. **Waxman**. Isn't it the case that prior to the change proposed in the regulations that would prohibit abortion counseling, that current guidelines, in fact, require family planning clinics to do abortion counseling?

Mr. **Windom**. Well, the regulation before did say that the counseling for abortion was to be allowed.

Mr. **Waxman**. I'm sorry?

Mr. **Windom**. Counseling for abortion was to be one of the components.

Mr. **Waxman**. So prior to your change in the regulations, the guidelines said that clinics had to do abortion counseling.

Mr. **Windom**. These were the guidelines that included that.

Mr. **Waxman**. So you didn't clarify anything. You reversed current policy and said now they can't do abortion counseling. Before they could and then you told them now you can't.

Mr. **Windom**. The guideline before allowed that to be performed.

Mr. **Waxman**. Required it to be performed, didn't it?

Mr. **Windom**. Since 1981 is when that was required.

Mr. **Waxman**. It was required as one of the nondirective pregnancy option counseling matters to be discussed. Abortion was to be discussed as one of the options. Abortion counseling was required by the regulations prior to the change of administration policy.

Mr. **Windom**. In fact, in reviewing those regulations and guidelines, we felt that this particular aspect of the abortion counseling which was provided there was inappropriate for the overall scope of the total title X regulation.

Mr. **Waxman**. Well, that is not confusion about what the law is. That is a change in interpretation of the law, a reversal of policy, isn't it?

Mr. **Windom**. Just one of the aspects of the overall regulations. Others involve counseling for adoption——

Mr. **Waxman**. Abortion counseling is what I am discussing. We are talking about whether abortion can be discussed as a pregnancy option. There has been a reversal position by the administration, not a clarification of some ambiguity. Let me go on and ask you further this.

As you know, three different Federal court judges have enjoined the Department's February 1988 regulations. In the Boston case, Judge Walter Skinner issued a permanent injunction. In so doing, Judge Skinner stated that he assumed that "the Secretary, as a responsible public official, would apply this judicial determination evenhandedly to all similarly situated entities in the United States."

Despite this, just 3 weeks ago, the Deputy Assistant Secretary for Population Affairs, Nabers Cabaniss, sitting right next to you, filed papers with the district court for the southern district of New York in which she declared her intention to implement the Federal regulations against any title X grantee not covered by an injunction.

Would you address the apparent discrepancy between Judge Skinner's opinion and Ms. Cabaniss' action. Do I have your assurance that the Department will not seek to implement the February regulations against any agency that is not covered by three injunctions while the case is on appeal?

Mr. WINDOM. Mr. Chairman, I feel it would be most appropriate if Miss Cabaniss responded to that.

Miss CABANISS. Mr. Chairman, we stated in the court in New York that we would intend to issue and implement the regulations where not enjoined, if not impractical. We have not received clarification on the full scope of the injunction in Boston.

One of the plaintiffs, NFPRHA, has supplied their membership lists to us. One of the other plaintiffs, American Public Health Association, has not yet done that. Pending clarification of the scope of the injunction, we will not implement the regulations and we have so instructed our regional offices.

Mr. WAXMAN. So if you find there is a family planning clinic not covered by a specific injunction because it wasn't actually a party to the lawsuit, do you plan to then go ahead and implement the regulations as to that family planning clinic?

Miss CABANISS. If there were only one clinic out of 4,000 across the country, clearly we would not. We would have to determine how many grantees and how many clinics are not covered by the injunction and make a determination, but until we know the full scope of that ruling, we can't make such a judgment.

Mr. WAXMAN. That is your policy only if one clinic isn't covered. There are thousands of clinics around the country.

Miss CABANISS. There are 4,000.

Mr. WAXMAN. I don't know how many were covered in each of the lawsuits. Do you feel you have legal authority to go ahead and implement the regulations to any of these other clinics—1 or 500, 1,000 just because they have not been named as a party to the lawsuit.

Miss CABANISS. Again, we would have to make that determination and perhaps Mr. Robertson could respond to that, but we will make that determination when we have information on what the scope of the injunction is.

Mr. WAXMAN. Mr. Robertson, you are the general counsel for the Department of Health and Human Services. There is an injunction that has been promulgated against the Department from enforcing the regulations. Do you think the injunction can be enforced with respect to other grantees that simply weren't parties to the action?

Mr. ROBERTSON. Mr. Chairman, we are very much aware of the judge's words in that order and have conferred with the Department of Justice on this issue and have been advised by the Department of Justice who is representing the Department in the pending litigation, that indeed the Department could proceed with partial implementation in those areas that would not be specifically covered by the scope of any of the existing injunctions.

Mr. **Waxman**. You say the scope. What does that mean? If the judge comes in and says what the Department has done by regulation is not consistent with the law and you have no authority to issue such regulations, would that permit you to go ahead and enforce those regulations against other grantees simply because they weren't parties in the action?

Mr. **Robertson**. That it is what we have been advised by the Department of Justice. And under the order by the court in Boston, that partial implementation could proceed once we have determined the specific scope of that order.

In other words, which grantees are encompassed under that order, that grantees not specifically covered under that order, or the orders from the court in New York.

Mr. **Waxman**. What is the purpose to be served? Is it simply to require that every grantee file another separate legal action and every district court in this country waste money and time for both sides? What purpose can possibly be served? If you have been told by a judge you don't have the authority to issue these regulations why try to implement them at all? Why can't you wait until there is a final determination before you force other people to get the same injunction? The issue has been litigated and an injunction has been granted. Shouldn't that stand as a precedent for other cases.

Mr. **Robertson**. I would do that as a program of policy determination. I was addressing what I understood your specific question with respect to the legal analysis as to the scope of the injunction from the court in Boston.

Mr. **Waxman**. So it is a policy determination. Let me ask Dr. Windom—since you are in charge of the policy—why would you want to require every grantee around the country to have to use funds to go hire lawyers and to go into court to make the same case for an injunction?

What policy or purpose can be served by trying to enforce the regulations against some grantees simply because they weren't named as the original parties to the lawsuit?

Miss **Cabaniss**. Let me, if I may, respond to that. First of all, we do not know yet the scope of the injunction. Therefore, we do not know whether we will implement it on some grantees and not on others.

Mr. **Waxman**. If the scope of the injunction is such that it says you don't have the authority to issue the regulations, wouldn't that scope mean you don't have authority to enforce them against any grantee?

Miss **Cabaniss**. Clearly we will abide by what the courts tell us to do. But if the courts are not speaking for all grantees across the country, our intent and our purpose is to very clearly separate abortion from family planning. That is the mission of the regulations. We believe it is consistent with the statute, with the legislative history.

Mr. Waxman. I know you believe that, but the courts, where the issue has been litigated, don't agree with you. The courts say you don't have the authority to issue these regulations. Now you are saying, however, as I understand it and correct me if I am wrong, that you, have the authority to say, unless a particular grantee is involved in a specific piece of litigation where an injunction has been issued, you can go ahead and try to enforce the regulations on that clinic and make it to go to court to file to get an injunction for its own particular case.

How can you justify doing that?

Miss Cabaniss. If one particular judge does not speak for the whole Nation, as I understand has been the case in the opinions that have been issued so far, then clearly we don't interpret him as speaking for the whole Nation. We will abide by——

Mr. Waxman. Is that a policy decision or a legal decision?

Miss Cabaniss. The law tells us we do not have to implement—excuse me. We can implement. We are not enjoined. We will have to make a policy decision with regard to where is that practice and is it practical.

Mr. Waxman. Well, Dr. Windom, your people have declined to answer staff questions about these regulations because the Department is engaged in litigation.

Now, it seems to me that you have a choice here. You could agree that the injunctions issued in litigation apply to all grantees or you can disagree and say that the regulations are in place for some grantees. As I understand it, we are being told regulations are in effect for some grantees. If you say that they are in force, I believe you must answer all my questions about them.

It is inconceivable to me that you believe there can be executive branch activities for which you are not accountable to either the Congress or the courts. If you are not going to commit to the policy that these regulations will not be enforced against potential grantees while the litigation is continuing—and I gather that is the testimony of your assistant, Miss Cabaniss—then I want to have your full cooperation in answering our questions about these regulations.

Mr. Windom. Mr. Chairman, we do not have the information yet to know what numbers we are speaking of, as far as a total of 4,000-plus clinics that we have, to know the scope of the involvement of the injunction right now or the legal affect on how many.

If it turns out there is a great majority, high number that that does enjoin, then we will certainly consider waiting to see the reaction to that.

Mr. Waxman. If you are prepared to enforce these regulations against any grantees, it seems to me you should be prepared also to answer our questions. Are you prepared to answer questions about these regulations?

Mr. Windom. We are not enforcing those regulations against any grantee at this time.

Mr. Waxman. At the present time.

Mr. Windom. We have not implemented the new regulations at this time on any grantee.

Mr. Waxman. Then my statement to you is if you start enforcing those regulations, we are going to expect that you will have to come before us and answer all the policy questions about those regulations, which heretofore the Department has refused because the claim is that you are in litigation.

Mr. **Windom**. Yes, that is our legal counsel guidance at this time.

Mr. **Waxman**. We will accept that so long as you are not going forward with those regulations. But if you go forward with those regulations and implement them as to some grantees, then you have got to answer to the Congress about those regulations. As to those grantees, there is no litigation and so our questions must be answered.

Mr. **Windom**. Yes.

Mr. **Waxman**. OK. I have other questions, but I want to give Mr. Nielson an opportunity to pursue some of his and we will go back to another round.

Mr. **Nielson**. Thank you, Mr. Chairman. I have a number of questions which have been submitted by Mr. Bliley.

I wondered if they can be submitted to the witness directly.

Mr. **Waxman**. Written questions? Without objection, we will submit written questions to the Department and ask that you respond in writing.

Mr. **Nielson**. Thank you.

In 1982, the GAO report the chairman referred to was issued about the abortion prohibition in title X, how it was working. And in addition to section 1008, which specifically prohibits the use of funds for abortion, are there any other regulations or any other statements or any other things that you deal with this issue, that state the language about the program being free from abortion?

Mr. **Windom**. Mr. Neilson, Ms. Cabaniss is director of that program. She can give more specific answers.

Miss **Cabaniss**. In addition to section 1008, there is substantive legislative history that makes it clear that a family planning program was in no way intended to be involved in abortion activities. Indeed, Congressman Dingell in introducing 1008, made one statement if there is any direct relationship between family planning and abortion, it would be this; that properly operated family planning programs should reduce the incidence of abortion.

He went on to say that abortion should not be encouraged or promoted in any way in the title X Family Planning Program.

Mr. **Nielson**. You have been criticized in the Department for paying too much attention to the abortion side of title X. With all due respect, it might be that you concern yourself too little with that aspect because it has taken you 5 years to look at the regulations and to perhaps adopt the GAO recommendation.

Would you respond to that, please?

Miss **Cabaniss**. We share the concerns with the time that it has taken to really take substantive action to deal with the connection between abortion and family planning and we are just pleased that we have finally taken action to get abortion out of title X.

Mr. **Nielson**. Now, let me get to the first question I really have. That is, you apparently object to the H.R. 1769, Waxman-Madigan bill, to reauthorize title X with substantially no changes. You object. Would you detail the reasons for your objections or what your objections are? And also while you are at it, do you have the same objections or different objections to Senate bill 1366?

Miss **Cabaniss**. If I may answer that question, the two bills are very similar. We are unofficial on S. 1366. We have not filed a bill report on the House bill.

Mr. **Nielson**. Can you tell me your objections to S. 1366?

Miss **Cabaniss**. Our concerns are threefold. The primary concern is the administration supports a State-administered family planning program. The bill before the House is not a State-administered family planning program. It would continue the program as is.

So our primary concern is that it is inconsistent with the major reform in the program, which we would like to make.

Mr. **Nielson**. Was that recommended in the GAO report, to be State-administered?

Miss **Cabaniss**. That was not part of the GAO report, no, sir.

Our further objections relate to the expanded authorities for contraceptive research and the expanded authorities are community-based information and education. We don't believe those authorities are necessary in the family planning program. We believe a sufficient authority exists for those activities.

Mr. **Nielson**. Where?

Miss **Cabaniss**. In title X itself. I can get you this particular section. Our final concern is that it is beyond the budget request for this administration.

Mr. **Nielson**. So basically, it does not State-administered that you would prefer, it expands the powers beyond what you think it should have, and three, it costs too much.

Is that basically it?

Miss **Cabaniss**. Right.

Mr. **Nielson**. Are any title X used to support clinics that provide contraceptives to teenagers, to your knowledge?

Miss **Cabaniss**. There are a variety of different definitions of a school-based clinic. Based on an informal survey of our grantees——

Mr. **Nielson**. Do you provide funds to any of the teenaged clinics?

Miss **Cabaniss**. We don't appear to be funding direct contraceptive services in schools. We may be providing services relating to the contraceptive distribution such as prescriptions, family planning counseling. We do not appear at this time to be actually involved in distributing contraceptives in schools.

Mr. **Nielson**. Dr. Windom, would you tell me what the parental involvement there is in the title X program?

Mr. **Windom**. Well, we certainly encourage parental involvement, but by statute this does not direct it. We see that it does vary from clinic site to site. Wherever possible, this is encouraged and we try to have the teenager involved with the problem to certainly talk with and share that with the parent.

We cannot obligate that.

Mr. **Nielson**. In my native State of Utah, we have what some people call the squeal law. Our law requires parental consent, if a teenager receives, if she is requesting contraceptive drugs or devices paid for by Federal funds. The courts have felt that Federal funding under such a law is illegal.

Therefore, your family planning funds have been revoked. Do you think that that is right? Do you think that we should have had the funds revoked because the State has a so-called squeal law?

Mr. **Windom**. According to the law that would be a violation. I presume it would have to be for the courts to follow. I don't think that would preclude the encouragement of the parental involvement.

Miss **Cabaniss**. To add on that, I think clearly the administration supports efforts to involve the family and supports parental notifications and parental consent. However, our regulations to accomplish that were not upheld in court, and therefore in order to allow Utah to do that, separate legislative authority would be needed.

Mr. **Nielson**. But don't you think by cutting off the funds it denies the country the opportunity to see whether such a program would work or not.

Miss **Cabaniss**. We would concur in that, and we would support legislative efforts to allow that sort of activity.

Mr. **Nielson**. What type of research do you do under title X? You mentioned you didn't want to expand the research powers as the Waxman-Madigan bill could do. What kind of research do you do currently?

Miss **Cabaniss**. Our research is directed toward service delivery improvement. We have funded a variety of research to help clinics better deliver services that includes projects to promote male involvement in the delivery of family planning services, to promote better integration of services between family planning clinics and sexually transmitted disease clinics, as well as research on natural family planning and a variety of management issues in title X.

Mr. **Nielson**. Are any funds from title X used for sex education in the schools?

Miss **Cabaniss**. Yes. I assume that is used for sex education.

Mr. **Nielson**. Do you have any details about that?

Miss **Cabaniss**. We would not have numbers on exact amount.

Mr. **Nielson**. Could you supply details?

Miss **Cabaniss**. We can. Clearly, there is no prohibition in the current law for that being done.

Mr. **Nielson**. Have you evaluated or reviewed the progress for those particular programs?

Miss **Cabaniss**. We have not.

Mr. **Nielson**. Would you do that? I think it would be very important for you to supply the information to how much—what funds are being used for sex education and what has been the effect of those funds.

Miss **Cabaniss**. We would indeed like to have information on that, effectiveness of title X.

Mr. **Waxman**. Will the gentleman yield to me?

You want to find out how much of title X funding is going into sex education. Wouldn't counseling a teenager about sexual activity and contraception and personal responsibility be sex education?

Mr. **Nielson**. Yes, to some extent. I was talking about formal, classroom presentation, however.

Mr. **Waxman**. You want to limit your inquiry to formal classroom education about sex?

Miss Cabaniss. His question was about what sex education do we do in schools?

Mr. Nielson. How many of those sex education on a formal, classroom type setting rather than individual counseling, how much of that comes from title X funds? I would like to have that information to the extent you can provide it and also an evaluation of how effective it is.

I have other questions. Perhaps you would like another round and I have a few more questions.

Mr. Waxman. Fine. Dr. Windom, you just told Mr. Nielson parental involvement varies from clinic site to clinic site. Could you submit studies for the record that indicate that parental involvement varies from clinic site to clinic site?

Mr. Windom. Yes. The degree and absolute amount and to what extent with each person, each counselor is involved is often different. I think there is some degree of maybe more encouragement by one counselor in one area compared to another.

Mr. Waxman. I am talking clinic site by clinic site. That was your statement.

Mr. Windom. Of variation in the degree of commitment or involvement, I don't know of any studies. We haven't done any per se but we know we hear in some areas representatives in those clinics are more in the way of trying to get parental involvement with the teenagers.

Others are maybe not as aggressive but there are no tangible specifics.

Mr. Waxman. Maybe on a personal, individual cases some may be more involved in urging parental involvement?

Mr. Windom. This has not been a study per se. It is on what we are hearing.

Miss Cabaniss. If I may add, the issue here is there are no specific regulatory requirements for how family involvement is to be promoted, therefore, there is not one standard for all 4,000 clinics. The clinics make their own judgments.

Mr. Waxman. I know there is no regulation that sets out a specific requirement, but the law, which I authored, says we want family involvement to be encouraged by the clinics.

Dr. Windom's statement a minute ago was that the spirit of the law is being lived up to in some clinics well and in other clinics not so well. He said that the degree of encouraging family involvement varies from clinic site to clinic site.

As I understand it, that isn't really an accurate statement based on any studies, but is simply an observation that some counselors may be more eager to involve in the family than others.

Is that a correct statement?

Mr. Windom. That is what we are saying, sir, yes.

Mr. Waxman. There seems to be some confusion about the reach of the title X program now and about my bill to reauthorize it. Does the current family planning program require grantees to provide services in school-based clinics?

Miss Cabaniss. No, it does not.

Mr. Waxman. Is there anything in the bill that encourages such clinics?

Miss Cabaniss. Under current law, no sir.

Mr. **Waxman**. Is there anything in the legislation that we have introduced that would encourage that?

Miss **Cabaniss**. We assume that that expanded provision was added for a particular reason and that you saw some need for an expanded authority.

To my knowledge there is no explicit requirement in your bill to fund school-based clinics.

Mr. **Waxman**. Which expanded authority in the legislation are you referring to?

Miss **Cabaniss**. The community based information and education services.

Mr. **Waxman**. That is not for contraceptive information, only for school-based clinics; isn't that correct? Is that your understanding?

Miss **Cabaniss**. It would be for a variety of types of services that might be provided in school, sex education services, counseling services that might be provided. It does not, as I read it, apply to direct contraceptive distribution.

Mr. **Waxman**. Is there any reason to believe the Department of Health and Human Services would change its current policies to start school-based contraceptive clinics if this bill became law?

Miss **Cabaniss**. The position of the Department is that we are very concerned with the mixed message that is sent to adolescents by the provision of contraceptives in schools and we would not support expanding in any way the role of the title X program in offering such services at schools.

Mr. **Waxman**. So the bill does not provide for expanding contraceptive services in school-based clinics and you, at the Department, don't want to do that even though you may have some authority to do it.

So, therefore, whether this law is changed or not as it relates to school-based clinics for other purposes, it won't require you to provide contraceptive services at school-based clinics. You would not be inclined to do so?

Miss **Cabaniss**. That is correct.

Mr. **Waxman**. Do you have any reason to believe that the bill Mr. Madigan and I have introduced, H.R. 3769, will force HHS to fund abortifacient development?

Miss **Cabaniss**. Well, the Hyde amendment prohibits the funding of performance of abortion. One would assume that would also cover any clinics in which abortifacient drugs were provided to pregnant women for purposes of inducing abortion.

So under the Hyde amendment, we would assume we cannot fund abortifacient drugs at least as it relates to directly providing the drug to pregnant women.

Mr. **Waxman**. Is there anything in the bill Mr. Madigan and I have introduced that would change the policy in any way and require the Department to deal with development of abortifacient drugs?

Miss **Cabaniss**. We would have to, I think, know a little bit more about what your intention is in expanding the authority. Presumably, you are not happy with the authority in the current legislation and you have a reason for expanding that authority.

Mr. **Waxman**. How about your reading of the language of the bill?

Miss **Cabaniss**. Our reading of the language of the bill would not suggest that we would be required to fund abortifacient drugs and indeed the administration's policy is we will not and do not fund research on drugs for abortifacient purposes.

Mr. **Waxman**. I am a little confused about the desire of the administration to have the family planning program run exclusively by the States. Is that your desire? You want the States to run these programs excessively and not have funds go directly to some clinics?

Miss **Cabaniss**. Our proposal is the States run the programs and then they would delegate the delivery of services to clinics, hospitals, a variety of types of organizations as is currently done.

Mr. **Waxman**. Under current law, a State can come in and ask to be funded for title X purposes. In fact, the law even gives them priority should they come in and apply to take on this responsibility. Why would we want to do anything more? Evidently some States don't want to take this responsibility. Why would we try to force them to take on this responsibility?

Miss **Cabaniss**. Our effort is to minimize the Federal paper work and the Federal regulatory burden upon the States in delivering services and allow the States to operate family planning programs in accordance with local priorities and local standards; therefore, we believe that handing it over to the States and allowing them to spend the money for family planning services in accordance with their local needs and priorities is a better and more efficient way to deliver family planning services.

Mr. **Waxman**. I have no problem with States running title X programs if they apply with good, solid applications for funding. But there are 17 States who are not sole grantees. Either they can't run or don't want to run a good program or feel that there are others better qualified to do so.

Why would we at the Federal Government say that we are going to overturn a State decision not to come in and supersede the other grantees that they think are doing a pretty good job? I thought the conservative Republican philosophy was to let these local governments make the decisions for themselves.

Miss **Cabaniss**. That is exactly right and we are concerned that really since its inception, the title X program has been plagued by controversy. The controversies have primarily centered around abortion and around family and parental involvement in the program.

Mr. **Waxman**. Do you want to put all those controversies to the States and have them fight each of them?

Miss **Cabaniss**. We would like to see diversity in the program so States can administer the program in a way that meets local priorities and values and standards.

Mr. **Waxman**. You are not saying that the only reason those 17 States have not gotten grants is because of some Federal prohibition against them coming in?

Miss **Cabaniss**. There is no Federal prohibition against any State coming in.

Mr. **Waxman**. I would think the conclusion to be reached is that these States don't want to run the programs. What you are saying is if they don't want to run them either because they don't want to or because they think otherwise already doing it well, then the Federal Government is going to superimpose its judgment over theirs.

I have other questions, but I want to recognize Mr. Nielson and then I will ask further questions after that.

Mr. **Nielson**. Thank you.

I would like to followup on the question about why you think State programs would improve the program, in other words, having the administering through title X through the States. How do you think that would improve the program?

Miss **Cabaniss**. You mentioned the six in Utah in which you are not currently allowed to get parental consent. That is the sort of issue we believe the States can best address themselves.

Mr. **Nielson**. Isn't that part of the title XX?

Miss **Cabaniss**. That is correct.

Mr. **Nielson**. Parental consent is involved in a requirement of title XX but not of title X.

Miss **Cabaniss**. That is correct.

Mr. **Nielson**. Have you analyzed the difference between title X and XX had involving the parents has helped or not?

Miss **Cabaniss**. We are finding in the title XX program that family involvement is helping. It is definitely making a difference. If I could follow on to a previous question you asked about what evaluation has been done of sex education programs in title X, one of the divergences between title X and XX is XX requires evaluation. XX is held to a very high standard of let's look at the effect of these programs on teen pregnancy and teen sexual activity.

There has never been any mandate by congress that title X be held to a similarly high standard.

Mr. **Nielson**. Of the many States or grantees in a title X program, how would your program differ from the current program since many States are already involved with it? Let's put it this way, for those States which are already grantees under Title X how would it differ in those States?

Miss **Cabaniss**. If the State had particular priorities in the way of who should be served in the program, what types of services should be provided as a part of family planning, the degree of family involvement, those would all be issues that the State could decide.

Mr. **Nielson**. Would there be some administrative savings if the States took it over?

Miss **Cabaniss**. Yes. There would be a reduction of about 40 FTE's at the Federal level.

Mr. **Nielson**. Would that reduction provide additional services at the Federal level or would it be a net savings?

Miss **Cabaniss**. It would be a net savings.

Mr. **Nielson**. Is this a situation where we give the States the program without the wherewithal?

Miss **Cabaniss**. That would continue at current level.

Mr. **Nielson**. The savings would be at the Federal level and the State level should stay about the same.

Miss **Cabaniss**. A little more would be going to the State.

Mr. **Nielson**. The administrative costs saved at the Federal level would accrue to the benefit of the States?

Miss Cabaniss. That is correct.

Mr. Nielson. Are you aware of any State initiatives that are currently ongoing that are making inroads into the problem of teen pregnancy?

Miss Cabaniss. I can mention a couple that are going on in the title XX program, one of which is a program called, postponing sexual involvement, which has been implemented all across the entire State of Georgia and is showing reductions in teen pregnancy, birth, and abortion rates as a result of the program.

In Utah there is a program that has been funded under AFL out of Brigham Young University. It is operating not just in Utah, but in other States across the country and it also is particularly showing improved family communication around sexual issues and improved attitudes toward postponing sexual involvement.

Mr. Nielson. Would you say we are winning or losing the battle about teenage pregnancy?

Miss Cabaniss. I think we are making significant progress. The rates went way up in the 1970's. They have now leveled off and I think we are going to see some change in the trends in a positive way.

Mr. Nielson. Do we need some new solutions that have not yet been suggested to make the battle even faster?

Miss Cabaniss. We believe that would be one of the merits of a State-administered family planning program that would allow States to come up with many diverse approaches to the teen pregnancy problem through family planning.

Mr. Nielson. What about the Chairman's concern that some States would pursue the objectives to title X effectively and enthusiastically and willingly? Other States would do it grudgingly if at all? What is your answer to that argument?

I think it is a legitimate argument for the Chairman to raise. In other words, if a State is willing to do it, you will get some good results, if a State is reluctant, you may not get any results at all.

Miss Cabaniss. I guess we have a higher view of States and do believe——

Mr. Nielson. Maybe I am not really phrasing his objection correctly. That is how I perceived your question, Mr. Chairman.

Mr. Waxman. Would you yield to me? Right now under present law, States can take this program over and run it. They can subcontract and do the whole thing and in fact 33 States have done that. Seventeen have chosen not to.

My question is I hope the 33 that are doing it are doing a good job, but if 17 don't even want to do the job either because they don't feel it is their responsibility to take it on or they feel it is being done adequately, why should we at the Federal level tell them that there will be no family planning program in their State unless the State comes in as the grantee?

Miss Cabaniss. Mr. Chairman, a number of States operate their own family planning programs. We could not imagine the State would totally reject funds under the family planning program and refuse to operate it.

We would find that very unlikely.

Mr. Nielson. I have a question which you referred to in your answer to a previous question about the abortifacient drugs particularly RU-486. Is there any chance that the bill proposed by Mr. Waxman and Mr. Madigan could develop research on that drug and perhaps I was going to say supersede or at least go around FDA regulations and FDA application? Is there any danger of that?

Miss **Cabaniss**. There is no prohibition in his provision against any research on abortifacient drugs. That prohibition comes primarily through the Hyde amendment and also perhaps through section 1008.

Mr. **Nielson**. Could that drug, RU-486, come into the country without going through FDA approval?

Miss **Cabaniss**. I do not believe so.

Mr. **Nielson**. There is no danger of that?

Miss **Cabaniss**. No, sir.

Mr. **Nielson**. There is no way it could be marketed unless it goes through FDA as far as you are concerned?

Miss **Cabaniss**. That is correct.

Mr. **Nielson**. The other question, are you concerned about the new elements? You mentioned you didn't like the new expansions in the program. Would you be more specific as to why you don't like the proposals for expansion?

Miss **Cabaniss**. We believe the current law——

Mr. **Nielson**. Name them one by one as to which ones you object to, which ones you think might be all right, which ones you would modify.

Miss **Cabaniss**. There are primarily three expansions. No. 1, expanded authority for doing community based information and education. We believe that is already being done in the family planning program.

Mr. **Nielson**. Where?

Miss **Cabaniss**. It is being done in satisfactory fashion throughout 4,000 clinics we fund now as well as through a clearing house which we operate to provide information on a national basis.

The second expanded authority is for contraceptive research and investigative research on contraceptive effectiveness. We believe that authority is not needed. We have that authority under current law as well as throughout NIH statute and we are concerned about what is the purpose of expanding that authority.

Then the final expansion is an expansion in the budget and we don't believe that is——

Mr. **Nielson**. It is a consequence of the other; is it not?

Miss **Cabaniss**. Yes.

Mr. **Nielson**. What about the school base[illegible]ics? What is your objection to that? That is expanded in the b[illegible]

Miss **Cabaniss**. We are very concerned about the mixed message that delivery of family planning services or family planning counseling, we are concerned about the mixed message that gives to adolescents. We, therefore, do not support expanding the involvement of family planning services into schools.

Mr. **Nielson**. Thank you, Mr. Chairman.

I have no further questions.

Mr. **Waxman**. Thank you, Mr. Nielson.

A couple of points I want to pursue. First of all, I understand that Chairman Dingell disagrees with Miss Cabaniss' estimate of his role in the legislative history of title X with respect to the issue of abortion.

I know he has written a letter to Dr. Bowen expressing his view on this and I would like to have his letter be made a part of the record.

[The letter referred to follows:]

ONE HUNDREDTH CONGRESS

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WM. MICHAEL KITZMILLER, STAFF DIRECTOR

U.S. House of Representatives
Committee on Energy and Commerce
Room 2125, Rayburn House Office Building
Washington, DC 20515

October 14, 1987

The Honorable Otis R. Bowen
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Secretary:

It was with great disappointment that I read the proposed regulations for family planning clinics which were published in the Federal Register on September 1, 1987. The regulations appear to sanction excessive intrusion into the private operations of facilities which receive funds under Title X of the Public Health Service Act; they also appear to restrict unduly the activities which Title X recipients can conduct with federal monies. I would like to take this opportunity to express my concern that the Department has taken a very narrow view of the legislative history of Title X and has used its narrow view to construct a biased interpretation of congressional intent for the program. At a personal level, I protest in the strongest possible terms the misuse of my Floor statement from the debate during passage of the original family planning legislation in 1970. I request that this letter and its attachment be included as part of the formal comments on the proposed rules.

The Background section of the proposed regulations purports to establish congressional intent for the family planning set out in Title X. To establish congressional intent, your Department quotes two sentences from the 1970 Conference Report on Title X and three passages from my Floor statement on the original enacting legislation. The Department has conveniently ignored the intervening 17 years of congressional action on this issue. Since my statement was made, the Title X program has been reauthorized six times and has been the subject of at least 7 other pieces of legislation. Restrictions similar to those in the regulations have been specifically proposed and rejected during this period. An accurate legislative history would reflect the entire record.

In addition to relying on an incomplete legislative history, the Department has also quoted passages from my Floor statement out of actual and historical context to imply things that were not said and which may not be reasonably inferred. My statement was made in opposition to the use of Federal funds to support or encourage abortion as a form of birth control. The statement did not suggest, either expressly or implicitly, that family planning clinics should be prohibited from counseling pregnant women on any matter or referring them to appropriate facilities. Nor did the statement support the imposition of record-keeping, distinct facility requirements, constraints on political activity, or the taking of a negative oath by clinics. The proposed regulations erroneously suggest that the statement somehow supported these goals.

I regret that the Department has succumbed to political pressure to apparently misinterpret the congressional intent for Title X and to propose the current set of regulations. I had been hopeful that the Department would abandon this regulatory approach last February when the Department reprimanded then-Deputy Assistant Secretary Gaspar for circulating a memorandum which promoted what appeared to be Ms. Gaspar's personal agenda regarding Title X by using the same misconstrued reasoning as is used in the regulations. I communicated my views on these issues directly to you in a February 6, 1987 letter. Since the meaning of that letter was apparently unclear, let me state clearly for the Administration that I opposed Ms. Gaspar's attempts to restructure Title X, I oppose the current regulatory efforts to restructure Title X, and I will oppose such efforts to alter the program in the future.

Sincerely,

JOHN D. DINGELL
CHAIRMAN

COMMENTS

OF

CHAIRMAN JOHN D. DINGELL

COMMITTEE ON ENERGY AND COMMERCE

U.S. HOUSE OF REPRESENTATIVES

ON PROPOSED RULES 42 CFR PART 59--Federal Register Notice

September 1, 1987

at pages 33210 to 33215

I. INTRODUCTION

The proposed regulations issued by the Department of Health and Human Services on September 1, 1987 regarding compliance with a statutory proscription on abortion under Title X of the Public Health Service Act purport to rely heavily for their justification on statements I made in 1970 during floor debate on the original family planning legislation. The statements quoted are taken out of context and misconstrue legislative intent and history. As such they do not serve as a proper basis for the proposed regulations.

II. THE QUOTED STATEMENTS ARE TAKEN OUT OF CONTEXT

A. My 1970 floor statement in the Congressional Record in opposition to federal support or encouragement of abortion was fundamentally directed at the question of whether abortion constituted a justifiable form of birth control. I explored this question from medical, ethical, legal and international perspectives. My comments, by virtue of their very scope, acknowledged the complexity of the problem. They filled several pages in the Record and contained some 64 footnotes. The few sentences selectively cited in the Federal Register to support the proposed regulations distort the aim and meaning of my words.

B. My remarks did not suggest--either expressly or implicitly--that the legislation being considered intended or required a prohibition on non-directive counseling or referral of pregnant women to abortion facilities. Nor did they in any way intend, require or contemplate the imposition of record-keeping or distinct facilities requirements, constraints on political activity or the taking of a negative oath by clinics.

Rather, the original Title X law proscribed federal support or encouragement of abortion. Congress was then and remains now able to legislate any of the changes proposed by the Department.

C. The proposed regulations not only distort my remarks but conveniently ignore a crucial sentence in the Conference Committee Report. That sentence which immediately follows the two sentences quoted in the regulations established a clear congressional intent not to interfere with the activities of organizations supported by non-Title X funds. While the regulations later purport to uphold that intent, their practical effect would be just the opposite.

III. THE PROPOSED REGULATIONS QUOTE 1970 STATEMENTS WITHOUT ACKNOWLEDGING THE EVOLUTION OF THE LAW

A. My floor statement was made with specific reference to the state of the law in 1970. The statement noted that most states and in the District of Columbia abortion was illegal. My statement reflected particular concern about the federal government either sanctioning illegal conduct or effectively overriding state laws.

Irrespective of any government official's personal belief, it is undeniable that the Supreme Court's 1973 decision in Roe v. Wade has changed the legal and constitutional landscape rather dramatically. Some of the legal concerns that gave rise to many of my 1970 comments must now be viewed in a different light. Quoting selectively from my comments without acknowledging changes in legal precedent is plainly deceptive. It also underscores the lack of a substantive basis for the proposed regulations.

B. The Department has attempted to exploit comments made in 1970 to bolster a ban on referral and counseling. Such a ban is not justified under current law. Inasmuch as my statement was delivered during a period in which abortion was illegal in virtually every state, legal liability could then have attended any part of the referral process. With abortion a legal option, the failure to adequately apprise a patient of her medical options can itself give rise to legal liability. The proposed regulations neglect to address these central facts.

C. Finally, even if my statement had not made specific reference to the state of the law in 1970, rules governing statutory interpretation of legislative intent require reference to the state of the law at the time legislation is passed. Likewise, legislation enacted after 1970 including reauthorizations and appropriations of Title X were based and should be interpreted on the state of the law as it had then evolved.

IV. THE PROPOSED REGULATIONS SELECTIVELY QUOTE MY STATEMENT WHILE IGNORING CHANGES IN MEDICAL SCIENCE AND PRACTICE

A. My statement specifically referred to and was based on the state of medical science in 1970. As noted, medicine's ability to detect severe birth defects early in a pregnancy was then quite limited. It has improved appreciably in the intervening years.

B. Further, in 1970, the medical community did not maintain a consensus about the medical necessity of informing a woman of her right to an abortion. Today there is a consensus. It is reflected in current program guidelines. That consensus derives not merely from concerns about legal liability but from concern about appropriate practice of medicine and ethical standards which require disclosure of options.

V. THE PROPOSED REGULATIONS DISTORT THE LEGISLATIVE HISTORY AND INTENT OF TITLE X.

The discussion of virtually every proposed regulation is preceded with a reference to the legislative intent of Title X. Such purported intent, the proposed regulations suggest, is defined by a few remarks selectively quoted from my 1970 statement as well as two sentences from the 1970 Conference Report.

The proposed regulations effectively claim that the few remarks selectively quoted from my statement and from the original conference Committee report constitute the entire legislative history and intent of relevant portions of the Title X statute. Such a claim lacks a legal basis and is misleading.

The Title X program has been reauthorized six times and has been the subject of at least seven other pieces of major legislation over the past seventeen years. Legislative history and intent derive from that entire record. Moreover, that record serves as a rejection of the regulations proposed. Reauthorizations and appropriations have given implied or express support for the program as it has been operated over the past several years.

V. SUMMARY AND CONCLUSION

The past two decades have witnessed dramatic changes in law and medicine which have undeniably affected the right of women to obtain information about abortion. During that same period, the Congress has spoken frequently to lend its support for the Title X program as it is currently operated.

Had the Department squarely acknowledged these facts it would not have sought to justify sweeping changes in the program by relying on a tiny fragment of the historical record, and one that is taken out of actual and historical context.

Nonetheless, if the Department still holds fast to the belief that my comments constitute the relevant legislative intent for its proposed changes, let the record be clear: neither the contents of my 1970 statement nor subsequent legislative history cede to the Department the right to implement any of the changes it proposes.

cc: Office of Management and Budget

Mr. Waxman. Without objection. You think title XX is doing a good job?

Miss Cabaniss. We do think positive results are coming out of the title XX program, yes, both in terms of services to pregnant and parenting teens as well as services to non-pregnant teens.

Mr. Waxman. Why then does the administration recommend to the Congress that we phase out title XX then?

Miss Cabaniss. That is no longer the proposal of the administration. The proposal is that we fund the program at $10 million. That was the proposal a year ago and since looking into the program further, particularly as it relates to the adoption issue, the administration realized that was not a wise proposal and we are supporting continued funding of the program.

Mr. Waxman. You would like to have the States run the family planning programs and make the decisions as they see the needs in their own State; is that correct?

Miss Cabaniss. That is correct.

Mr. Waxman. What if a State decided it wanted to provide abortions along with family planning services? Should we prohibit that?

Miss Cabaniss. That is prohibited in the proposal we will be submitting to Congress.

Mr. Waxman. Why can't the States make that decision for themselves if they are going to make the decision of running the family planning program?

Ms. Cabaniss. We believe there are certain parameters that should be set at the Federal level. We are proposing, for example, the money only be spent on family planning services. It cannot be spent on some other type of service unrelated to family planning.

We also believe general guidance should be set on what we mean by family planning and one of the things we don't mean by family planning is the support of abortion as a method of family planning.

Mr. Waxman. So you would have the Federal law in effect as it relates to abortion services, even if the States were running the family planning program?

Ms. Cabaniss. That is correct.

Mr. Waxman. Mr. Windom, let me ask you a professional question. I am not talking to you as Assistant Secretary of Health, but as a practicing cardiologist, in fact, a well-known cardiologist, I believe.

Did you talk to your patients when they came to you with a heart problem? Did you discuss various treatments that they might consider such as bypass surgery or using a cardiac balloon or using various drugs?

Mr. Windom. Certainly, yes, sir.

Mr. Waxman. Suppose Medicare came in one day and told you by regulation that you couldn't talk to your patients about bypass surgery but only about balloons or certain drugs? In other words, under this regualtion, it would be illegal for you to use Medicare money to talk about the option of bypass surgery.

Would you support such a policy? Should the Government tell you how to practice medicine?

Mr. Windom. I do not feel that would happen, sir, because I don't think that would be——

Mr. Waxman. But if it did, wouldn't you be against it?

Mr. **Windom**. Yes.

Mr. **Waxman**. Now, abortion is legal and in some cases it is a recommended surgical procedure in the United States. How is the department's regulation prohibiting doctors in family planning clinics from discussing abortion any different from the Health Care Financing Administration telling cardiologists not to talk about bypass surgery? I think Mr. Windom can answer this as a professional on his own.

Mr. **Windom**. In that case, Mr. Chairman, the individual who is pregnant is referred to a physician for—is able to be referred to a physician for discussion of the abortion but abortion is not a part of family planning.

Mr. **Waxman**. If a doctor is talking to a woman who is pregnant, and she wants to talk about various options that are available to her, should that doctor be prohibited from discussing abortion as an option?

Mr. **Windom**. If she is pregnant and planning a family then he would discuss her option to carry the baby and if she did not wish to do that—wished to keep the baby, the option of adoption is given to her.

Mr. **Waxman**. What about abortion?

Mr. **Windom**. That is not part of family planning. That is termination of a pregnancy in which she would be referred to a physician in the community for prenatal care if she raised that issue.

Mr. **Waxman**. A woman comes into a clinic. She is a middle-aged woman. She is pregnant. She has as viral encephalitis or mononucleosis and CNV. Or take a 13-year-old girl who is pregnant from a rape. Consider a mother of a dead Tay-Sachs child who is pregnant with a second fetus that is determined to have Tay-Sachs also. Or young drug abusing woman who is pregnant and tests positive for the AIDS virus. Let's say any of the these women comes into the clinic and talks to a physician.

Should that physician be prohibited from saying to these women, in looking at their individual circumstances, thus abortion is a medical procedure that is available to them?

Mr. **Windom**. The direction would be to refer her to that site where she could, to that physician where she could seek the guidance and direction for medical care.

Mr. **Waxman**. If she elected to have an abortion, certainly she would have to be referred to a place where the abortion could be performed. But in discussing her options, why can't a physician be able to tell a woman in any of those circumstances that abortion is a possibility? Then the doctor could give a referral if that is what she wanted?

Mr. **Windom**. The title X program that we support and which we have in effect is for prepregnancy guidance and direction. Once a pregnancy has occurred, that is not a part of the title X program. Thus, if the individual is pregnant, she is referred——

Mr. **Waxman**. You don't think the program ought to be involved in abortion activities but I am asking you to discuss this issue as a physician. If a woman comes mistakenly to your office thinking that you are available to answer questions on this subject, do you feel you should not be permitted to talk about abortion as an option?

Mr. **Windom**. That circumstance, if I were under the clinic direction of the Federal funding as it is now, I would not be able to do that. I would refer her to those who could do that for me.

Mr. **Waxman**. How is that different from the case of Medicare's paying you to handle an elderly patient's heart problem and the Government comes in and says to you: "Doctor, you are receiving Medicare's payment for this patient. Don't you dare talk to this patient about bypass surgery. We have had a lot of costs for bypass surgeries. We don't want them encouraged. We don't even want you to discuss it."

Would you think there is any difference between those two cases?

Mr. **Windom**. Medicare is not a program of planning or directing care. It is strictly a financial support mechanism. If you had a Federal program though that you are speaking of, then we would have to consider the evaluation at that time. But it is entirely different between Medicare giving dollars for payment of services than would be the case of title X which is specifically a family planning program.

Mr. **Waxman**. Should a woman be turned away from a family planning clinic if she is pregnant? Should she be turned away and told, sorry we don't want to talk to you here. This program is designed to avoid pregnancy. You are already pregnant; go somewhere else.

Mr. **Windom**. She would be directed to medical services for pregnancy if she is already pregnant.

Mr. **Waxman**. You think the clinic ought to refer her elsewhere and not discuss any options?

Mr. **Windom**. Yes.

Mr. **Waxman**. What about adoption? That is not contraceptive planning?

Mr. **Windom**. No, but that is the alternative to how to deal with a baby after birth.

Mr. **Waxman**. The fact is abortion is also an alternative to deal with a pregnancy after conception.

Mr. **Windom**. But the statute prohibits the involvement of federal——

Mr. **Waxman**. You keep saying that the statute prohibits discussing abortion as an option because your regulations prohibit such as discussion and because the administration doesn't want any discussion of abortion as an option.

But I am asking you as a physician. If a woman comes in to see you and she is already pregnant, would you feel in any way the Government should tell you not to be able to mention abortion to her as an option?

Mr. **Windom**. If I am working in that clinic under the direction it is now and receiving Federal funds for the program, then I would not be able to do so.

Mr. **Waxman**. Then should the government tell you you have to discuss adoption with her?

Mr. **Windom**. No. They don't have to tell me. I could. That is allowed.

Mr. **Waxman**. You think that should be allowed?

Mr. **Windom**. Because you are not terminating a pregnancy at that point. The pregnancy would be continuing.

Mr. **Waxman**. What if she brings up the subject. She says: "Doctor, I know adoption—giving the baby up for adoption is one choice. I know bearing the child—even though the child is carrying Tay-Sachs—is another choice. I know the fact that I have been raped and that I can carry this baby to term is a choice, but I don't want to do that."

I have heard about abortion. Do you think you should say to her at that point, "I am sorry. Let's discuss the issue no further. I have no right to discuss this with you"?

Mr. **Windom**. My job at that particular time would not be deliver or direct prenatal care.

Mr. **Waxman**. You are not going to deliver?

Mr. **Windom**. I would refer her to those who would be in turn able to give her the direction when she is pregnant as far as carrying out her pregnancy.

Mr. **Waxman**. Let's say she comes into the clinic and she wants to be pregnant. She is excited about the possibility. She takes a pregnancy test but in the work up you also find that her health is endangered.

Miss Cabaniss, I don't understand why you have to be whispering to him. I am asking Mr. Windom these questions in his capacity as a physician. Are you a physician, Mrs. Cabaniss?

Miss **Cabaniss**. No, Mr. Chairman, I am not.

Mr. **Waxman**. That is all I wanted to know. Mr. Windom, you are a physician and you have had more experience in dealing with patients. I think you can give us guidance on this. A woman comes in to see you and she is really excited about being pregnant. She wants the pregnancy test. You do a work up and find she has got a disease she didn't realize she had. Her life is in danger if she carries this pregnancy to term.

Do you think you are permitted to say to her, I have got some bad news for you and I think through with her, guide her through the various options, one of which maybe she could decide to have an abortion?

Mr. **Windom**. At very early stage if her life is in danger, she is certainly not a candidate to stay in the clinic. She has to go to care. That is where she would be directed for care.

Mr. **Waxman**. Can the doctor suggest that one of the options open to her is to go somewhere else to have an abortion?

Mr. **Windom**. That is where the analysis would be made to determine whether her life was in danger to the point the pregnancy would endanger her and possibly cause her death.

Dr. **Waxman**. Do you think a doctor under those circumstances where the life of the mother is endangered could discuss the option of abortion?

Dr. **Windom**. That is what would be done if she was referred to the doctor that would consider her pregnancy.

Mr. **Waxman**. Do the regulations now being considered by the department say abortion can be discussed as an option if the doctor determines the life of the mother is in danger? Do they say in other circumstances the doctor may not discuss abortion?

Mr. Windom. When the mother's life was in danger and that was the time the recommendation is made to save here life.

Mr. Waxman. Could you, as a physician, work in a clinic as a physician that requires you not discuss abortion as an option except under very limited circumstances? Would you personally stand for that?

Mr. Windom. If I were in the clinic, sir, I would certainly abide by those directions and under what the limitations are.

Mr. Waxman. But would you feel as a professional physician that would be an infringement on your right to practice good medical science as you might see it for each and every case?

Mr. Windom. Working within that clinic you assume the responsibilities and also the obligations you have to meet to fulfill that job. Then you also realize you have the alternative to refer the patient to a source where that can be dealt with and continued as far as the rest of the pregnancy.

Mr. Waxman. Let's get to the cardiologist kind of situation. A woman comes in. She is middle aged, pregnant for the first time. She has a severe heart murmur and signs of increasing cardiac activity in the first few weeks of pregnancy.

Would you as a physician feel obligated to tell this woman about the option of abortion in her case?

Mr. Windom. That is beyond the scope of the clinic, sir.

Mr. Waxman. I am not asking you about the clinic. I am asking you as a physician. If this woman came to see you as a private physician.

Mr. Windom. I would have to determine, one, whether we could manage her condition with the heart failure and if you manage all that and she goes through satisfactorily, fine. But if she can't be managed with drugs and with the program of adjustment to get her back to stable condition, then the question would be, is she going to die if this pregnancy continues, at which time the obstetrician taking care of her would have to make a decision as to what that general boundary is or when to offer the abortion that was going to save her life.

Mr. Waxman. Should she have a say in any of this? You don't know for sure she is going to die.

Mr. Windom. If you know her life is in danger to the point it would, you would have to discuss that with her.

Mr. Waxman. You say to her: "Your life is in danger. You may not be able to live through this pregnancy. You might recognize that fact and there is a legal procedure called abortion which you may choose to have under these circumstances."

You would say that to her; wouldn't you?

Mr. Windom. Yes.

Mr. Waxman. Any good physician would give her that information, even if you personally didn't like abortion.

Mr. Windom. That is correct.

Mr. Waxman. Do you think the Government should tell you you shouldn't discuss that with her?

Mr. Windom. No. She has the care of the doctor who is carrying her through the pregnancy, they have the opportunity to discuss options.

Mr. **Waxman**. Suppose that woman came into a family planning clinic and had a pregnancy test and during the other medical workup it was found she had this medical problem that might not permit her to carry the pregnancy to term. Now she is in a clinic where the doctor employed by that clinic knows there are rules and regulations.

Do you think it is reasonable to say to the doctor: "You can discuss with this woman the option of giving up the child for adoption. You can discuss with this woman the option of carrying the pregnancy to term. But she may not make it. However, you cannot discuss with this woman the option of going for an abortion somewhere else?"

Mr. **Windom**. Yes. She will be referred somewhere else if he felt, as he saw——

Mr. **Waxman**. Does she have to bring up the subject of abortion before the doctor can talk to her about it or can the doctor mention to her affirmatively that abortion is one of her options.

Mr. **Windom**. He cannot talk to her about that option. If it came to the point where he felt what he knew that indicated she needed further guidance in her pregnancy he would refer her for that.

Mr. **Waxman**. He would have to refer for the purpose of even discussing the option?

Mr. **Windom**. That is right because somebody who is going to carry her through the pregnancy needs to be able to step in as early as possible.

Mr. **Waxman**. OK. I have no further questions.

Mr. Nielson.

Mr. **Nielson**. I think obviously you know this is a continued attempt by this administration with these regulations to interfere with the practice of medicine, as any responsible doctor would do under the circumstances in dealing with a doctor/patient relationship.

It is a further effort to try to hinder the family planning clinics and to try to stifle the whole program. The idea of saying States ought to run it when 33 already do is a further effort of the administration to abolish the family planning programs and say to the States, run it if you want, but we don't want to have family planning at all.

Mr. **Waxman**. Mr. Westmoreland of my staff just raised another point and I will ask it. Suppose this woman goes to a clinic for poor people—not to a family planning clinic—but a community health center, for example. She has the same problem. She is pregnant, has cardiac problems. She may not live—may or may not live through the pregnancy. Do you think she ought to be informed by a doctor in that clinic, which is not a family planning clinic, that abortion is one of the choices she might make?

Mr. **Windom**. I am sure they vary in the type of clinics you are referring to and I am not sure what their directions or regulations are.

Mr. **Waxman**. What would you support? How about maternal and child health clinics? Do you think they ought to have the right in that type of clinic that deals with poor women to discuss this option? What is your personal opinion of that?

Mr. Windom. Personal opinion gets to the point where this is an issue that is going to affect her life and cause possibly her death during, if she carried it to termination, that decision has to be made by those who are not prohibited from doing it which these programs allow.

She would have to be directed to a program where she could have that guidance.

Mr. Waxman. Let's say the Federal Government is trying to decide whether it should prohibit abortion counseling or not and you were asked your view as a doctor. Should we prohibit a doctor from discussing this option with this woman in this clinic? After all if you mention the abortion option she may take that option.

Mr. Windom. That particular clinic prohibits that; that would have to be the way it is.

Mr. Waxman. A poor woman has no other choice. She can't afford to see you or some other doctor in private medicine. She goes to a maternal and child clinic supported by taxpayers who believe that a poor woman should get medical services while she is pregnant.

Do you think that is just unfortunate that she may not have the option of abortion even mentioned to her?

Mr. Windom. In that circumstance that would be the case.

Mr. Waxman. Thank you very much, all of you, for your presentation to us. We look forward to working on this legislation with you and to further discussing this issue. I hope we will not go through a lot of acrimony and that we can work these things out.

Thank you very much.

Our next witness is Dr. C. Earl Fox, State health officer, Alabama Department of Public Health. He has long been involved with the title X family planning program, from the State perspective, and is here today to address that issue. He is appearing on behalf of both the State of Alabama as well as the American Public Health Association.

Dr. Fox, we are pleased to have you with us today. Your written statement will be made part of the record in full. We would like to ask you to take no more than 5 minutes to make your oral presentation. By the way, we are going to have to be very strict with you and all the other witnesses scheduled to testify in enforcing the 5-minute presentation period. We will not be able to go beyond the 5-minute time period.

STATEMENT OF CLAUDE EARL FOX, STATE HEALTH OFFICER, ALABAMA DEPARTMENT OF PUBLIC HEALTH AND ALSO ON BEHALF OF AMERICAN PUBLIC HEALTH ASSOCIATION

Mr. Fox. Thank you, Mr. Chairman and distinguished members of the committee. I am Dr. Earl Fox, the health officer for the Alabama Department of Public Health. I am pleased to have the opportunity to testify regarding the reauthorization of the title X legislation.

I have been fortunate to have been able to work in the family planning program at all levels as a clinician initially 15 years ago actually providing family planning services, later served to administer the program at a sub-State and then later State level. I have served as a national child health director for 6 years and finally assumed responsibility of State health officer.

A comprehensive family planning results, in my opinion, in many benefits. These benefits include improved health by spacing the pregnancies, by early detection of health problems, and prevention of unwanted pregnancies. These benefits impact the total health of the individual, and the diagnostic services of the program enhance the concept of primary care of the patients.

Comprehensive family planning services represent an attempt to deal with health, social, and economic problems associated, at least in part, with the occurrence of unwanted and mistimed pregnancies in America.

For many poor women, entry into a system of health care often begins in the family planning clinic. Screenings and referrals for problems, as well as health education and counseling, are components of family planning clinic services in addition to a physical exam; related laboratory tests such as Pap smears and sexually transmitted disease testing; and the provision of contraceptive supplies. These services enable women to space and/or prevent pregnancies and achieve improved health through the prevention of high risk pregnancies, early detection of breast and cervical cancers, sexually transmitted diseases, hypertension and other health problem conditions. Infertility services are also provided for persons who desire pregnancy.

Information and education programs that are designed to achieve community understanding of the State program's objectives and to inform the community of the availability of services are ongoing in each program area. The service program is buttressed by a training program for clinic personnel, community education activities, and strict evaluation requirements to ensure program accountability.

In Alabama during 1987, a total of 83,372 women were provided medical family planning services. These patients received over 591,000 health screening services. Included in this total were 69,853 Pap smears; 76,455 biannual pelvic examinations, 63,394 urinalysis tests; 132,811 blood pressure determinations; 60,225 blood tests; 6,693 sickle cell tests; and 107,271 sexually transmitted disease tests.

In many States, the family planning program is a vital part of an integrated health care system that includes all personal health services such as prenatal care, child health services, WIC, cancer detection, sexually transmitted diseases detection and treatment, hypertension services and immunization. Many State programs have family planning service agreements with a majority of the Federally funded primary care projects in the south.

For the past 18 years, title X has been the primary force in our efforts to reduce the number of unintended pregnancies among teenagers and poor women in general. There are more than 5 million poor women and teens served through title X clinics each year throughout this country. Each year, there are more than 800,000 pregnancies averted—more than half among teens—through title X agencies. As a result, the title X national program helps avert more than 400,000 abortions each year.

Family planning not only has a positive impact upon the health status of the community, but it greatly reduces human suffering from wife abuse, child abuse, nutritional problems, and abject poverty. Infant and maternal morbidity and mortality are reduced as a result of successful family planning programs.

We are fortunate, at this time, to see aggressive movement from the national Congress and from many States toward reducing infant deaths. A major component of these reduction efforts is, and must continue to be, the provision of family planning services to low-income women.

Family planning is the primary Federal/State program aimed at the prevention of unintended adolescent pregnancies. The family planning program supports the establishment and maintenance of clinics, which is crucial in reaching geographic areas that are medically underserved. Because program participation is not limited solely to persons on welfare, the near-poor and many teenagers are able to avoid falling into poverty as the result of an unintended pregnancy.

The consequences of teenage pregnancy and childbearing have been well documented and widely publicized. While some teenagers assume the responsibilities of parenthood without major problems, particularly if they have of the support of their families, the consequences for most young people are adverse, and often long-lasting.

Teenage pregnancy continues to be a major problem in Alabama and the Nation. Half of all teenage pregnancies occur within the first 6 months after sexual activity begins. Unfortunately, most teenagers wait at least 9 months before seeking contraceptive advice.

Alabama continues to rank third in the Nation in the percentage of teen births as a percent of total births. An unwanted pregnancy can force a teen into a situation where she has to begin teaching another person about life before she has had a chance to experience it for herself. Family planning clinics encourage teens to involve their parents/guardians in their decisions about using contraception.

Each dollar invested in family planning by the government in any one year yields a savings of $2 in other health and welfare costs that would be associated with unintended births the following year. The cost/benefit is even greater among teens—a $3 savings for every dollar spent—because teen pregnancies and births are more likely to be problematic medically, and teenage parents are more likely to need welfare and other public benefits than their adult counterparts.

Our commitment to family planning continues to be based on three fundamental premises: that all persons should be able to determine the number and spacing of their children; that the timing and spacing of births is directly related to the health of mothers and children; and that the availability for family planning services to low-income persons can be instrumental in preventing or alleviating poverty and dependency.

Title X is vital in attempting to reach the targeted in-need population. I thank you for your past support of this legislation, and solicit your support in getting the title X legislation reauthorized.

Mr. **WAXMAN**. Thank you, Mr. Fox. Are you a physician?

Mr. **FOX**. Yes.

Mr. **WAXMAN**. You work for the State of Alabama?

Mr. Fox. Yes, sir.

Mr. Waxman. Do you believe that the ethics of your profession are put on hold while you work for the Government?

Mr. Fox. I would hope they would not be.

Mr. Waxman. Do you think it is ethical for a physician not to tell a patient that her life may be endangered and that in order to avoid that consequence there is a legal, medical procedure that may save her life?

Mr. Fox. Mr. Chairman, I believe that is an ethical responsibility and, in fact, I had a situation while working in the health department where that happened to me.

I had a woman, a 20-year-old woman who had two sisters that died from a previous pregnancy she came in for birth control pills. At the time of her first family planning visit she was already pregnant again, was in florid heart failure and really would have died if some referral had not been made at that time.

Mr. Waxman. If a doctor, even because there was some rule in the clinic, didn't discuss with a patient a possible medical operation and the patient then died or suffered grievous harm, could that doctor be sued for malpractice?

Mr. Fox. I would assume they could.

Mr. Waxman. Do doctors who deal with poor women in public clinics at the Federal or State level have immunity from the same medical standards of practice that other doctors have who are providing services to a private pay patient?

Mr. Fox. We ought to be held to a higher standard because many of those women don't have resources to go somewhere else.

Mr. Waxman. I find it incredible the Federal Government of the United States would say to poor women that even though we will pay for needed medical services we won't pay for one specific medical service. That is abortion. I find that disturbing. But I find it really extremely reprehensible to say we won't even tell a poor woman that there is an option that may save her life called abortion, even if we won't pay for it. I suppose that is a rhetorical statement but I certainly want to get my feelings on the record.

I just heard Dr. Windom make the administration's case for making title X into a block grant program. They have been trying to make this case for 8 years. Last year it was such an unpopular idea they couldn't even get anyone to introduce it as a bill.

Your State, I believe, is a title X grantee. So if there were a block grant you would be in the same kind of situation, I suppose. How would you respond to the idea of the proposal to make family planning program a block grant program as opposed to a Federal program as it is today?

Mr. Fox. Mr. Chairman, I prescribe to the saying if it ain't broken, don't fix it. My experience over the 15 years I have been in public health has been that the Federal family planning program in my opinion has been one of the best run and highest quality programs we have had the opportunity to deal with. The entities out there now providing family planning services, I think, are doing a good job. The program should be left pretty much as it presently is constituted.

Mr. Waxman. I understand that the State of Alabama is one of 36 State health departments that had commented on the HHS February 1988 regulations.

If these regulations were to go into effect what would be their impact on the delivery of family planning services in Alabama?

Mr. Fox. We feel they would certainly restrict our ability to provide adequate services, to make referrals and to give the type of service to women, particularly low income women, that we are trying to deliver throughout the health department clinics.

Mr. Waxman. Mr. Nielson.

Mr. Nielson. Yes. Thank you, Mr. Fox. I think my brother-in-law knows you are working in the State system down there in Alabama. You know the family planning clinics encourage teens to involve their parents in the decision about using contraceptives.

Mr. Fox. Yes, sir.

Mr. Nielson. Would you describe the steps that are taken to do that, to inform the teens and encourage them to involve their parents?

Mr. Fox. We have training programs statewide, we mandate to all of our employees and these are on going. Part of those training programs require all of our nursing staff, within the clinics, to encourage teenagers—regardless of the service they request—to involve their families, to talk to their parents about their sexuality, and to talk about contraception. This is an ongoing part of our entire statewide family planning program.

Mr. Nielson. Do you find title X and title XX are in conflict with each other or are the complimentary?

Mr. Fox. I don't believe they are in conflict. I would not like to see one to the exclusion of the other. Certainly there is room for both. Some individuals need to be counseled and we encourage trying to work with teenagers to delay the onset of sexual involvement, sexual intercourse. There are a lot of reasons to do that.

But we must recognize that many of teenagers are going to be sexually active. Out of 20,000 cases of gonorrhea in Alabama in 1986, 6,600 were in children age 10 to 19. I think there is room for both.

Mr. Nielson. You mentioned 3,372 women in the title X program in Alabama in 1987. Could you break that down as to how many of them were adolescents or how many were not.

Mr. Fox. Yes, sir.

Mr. Nielson. In general, could you break it down by age all the way through?

Mr. Fox. I don't have it with me, but I can tell you in general, one-third of our patient population are teenagers 19 and under. Less than 1 percent are under age 14.

Mr. Nielson. If you would supply that breakdown by age, I would be very interested. Also, could you break it down by income. How many would be considered low income?

Mr. Fox. If we have that information, I will be glad to give it to you.

Mr. Nielson. You stated teenage pregnancy continues to be a major problem in Alabama and the Nation. How are we doing on teenage pregnancy? Are we winning the battle against it or losing it?

Mr. Fox. I think we are winning it. Our pregnancy rate of 17.4 has been on the decline since the early 1980's so I think we are winning the battle although the rates are still very high.

Mr. Nielson. You say if it is not broke, don't fix it. Is it possible that the administration's approach to go to the State directly might be an improvement or do you think it better not to do that?

Mr. Fox. I have some concerns. We sometimes all tend to get upset with requirements for various programs but I think the family planning program, although we fuss sometimes about the things we have to do, certainly has a high set of standards, particularly as far as followup of medical problems such as annual Pap smears, I would be concerned in either a block grant situation or any type of different administration other than what we have now that the quality of the program might suffer.

Mr. Nielson. Is your concern that of the chairman's, that some States just won't do it?

Mr. Fox. I think that is true. There is a variety of interest among the States. Some States are more involved in it and also State health departments vary a great deal in their provision and involvement in direct medical services.

Mr. Nielson. I congratulate you. Apparently you have one of the better programs in the country and you personally are better qualified than most. I appreciate your testimony.

Thank you.

Mr. Waxman. Let me just ask you one more question. We have a possibility of title X programs playing a critical role in helping to prevent the transmission of the AIDS virus. Do you believe that we need a strong Federal and tight discrimination policy in place as part of any testing and counseling program that may be offered in family planning clinics?

Mr. Fox. Mr. Chairman, we are offering AIDS tests to all of our family planning patients on a voluntary basis, not a mandatory basis. We do support and are very interested in and think the Federal Government should initiate some type of legislation. I think it is going to be very difficult to go State by State and it needs to be there.

Mr. Waxman. Do family planning clinics have the resources in terms of dollars and personnel to carry out an adequate AIDS testing and counseling program?

Mr. Fox. I can't speak for the other agencies, Mr. Chairman. We are going to do it and pull the money out of other sources but our family planning dollars have not gone up very much during the last several years, as you know.

We are increasingly subsidizing our family planning program out of other moneys at the State level. I would assume that for most States, including ours, additional dollars would be needed.

Mr. Waxman. What would be the impact on the title X program if you were required to test and counsel every person who came through your clinic door?

Mr. Fox. It would cost us several hundred thousand dollars more than we spend right now. The AIDS test cost us on an average in our State laboratory approximately $10 per test. On the private market it would be between $50 and $100 per test. Multiply that by the number of patients—83,000. And some of those receive more than one visit a year.

The counseling itself is time consuming and should take anywhere from at least 20 minutes to an hour so it would be quite costly.

Mr. **Waxman**. Thank you, Mr. Fox. We very much appreciate your testimony and your willingness to be with us here.

Our third panel includes Ms. Jo Ann Gasper, former Deputy Assistant Secretary for Population Affairs, Department of Health and Human Services. In that capacity she was responsible for the day-to-day operations of the family planning program. The panel also comprises Stan E. Weed, Ph.D. director of the Institute for Research and Evaluation, Richard Glasow, Ph.D., director of education, National Right to Life Committee; and Mr. Michael Schwartz, resident fellow in social policy, Free Congress Research and Education Foundation.

Ms. Gasper.

STATEMENTS OF JO ANN GASPER, FORMER DEPUTY ASSISTANT SECRETARY FOR POPULATION AFFAIRS, DEPARTMENT OF HEALTH AND HUMAN SERVICES; STAN E. WEED, DIRECTOR, INSTITUTE FOR RESEARCH AND EVALUATION; MICHAEL SCHWARTZ, RESIDENT FELLOW IN SOCIAL POLICY, FREE CONGRESS RESEARCH AND EDUCATION FOUNDATION; AND RICHARD D. GLASNOW, DIRECTOR OF EDUCATION, NATIONAL RIGHT TO LIFE COMMITTEE

Ms. **Gasper**. Thank you, very much. I am delighted to be here today. I will be testifying as a former DASPA, Deputy Assistant Secretary for Population Affairs. I have had a lot of experience with family planning. From 1981 to 1987, I had oversight as well as operational responsibilities for the program. Therefore, I would like to tell you that there has been a conspiracy of silence and a cover-up regarding how title X is operated.

The President ordered the National Family Planning Program to be cleaned up of any taint of abortion. Unfortunately it required the President to act in this regard and that is because of the powerful influence of the abortion industry. It took a Presidential directive to begin the process to stop taxpayer support of abortion and abortion related activities by the National Family Planning Program.

Since title X was originally enacted, program practice has deviated significantly from program law and program policy. This lack of compliance with the law has resulted in a program which unlawfully promotes, advocates, and encourages abortion, a program which rapes the minds of children, undermines family values and operates without regard to community standards.

The President ordered HHS to issue regulations which will bring the program practice into compliance with law. All the regulations could go farther. They are a reasonable beginning. The regulations will prevent grantees from providing abortion counseling, something which has never been legally permitted within the program.

Let's set the record straight. Title X grantees like other organizations that receive Federal funds have an option. They may operate the programs the way Congress intends, or they shouldn't take the taxpayers' money. The choice is theirs.

What is not supposed to happen is that tax money is taken and then the law disregarded. Unfortunately that is what has happened with the title X family planning program. The money has been taken and the law has been ignored. The abortion industry is very upset with the regulations and they are upset for a very simple reason: They will lose money. I can't tell you exactly how much, but a lot.

When you look at their arguments in opposition to the regulations the abortion providers talk about there having been $150 million of support in subsidies to abortion and abortion related activities out of the title X program. I should point out that abortion providers often frequently claim their constitutional rights will be denied if taxpayers do not support their programs.

I should say that don't forget roughly a third of the people who receive services from title X are children who get services without any parental consent or notification. Opponents of the regulations are arguing preventing abortion counseling violates constitutional rights. That is like saying that taxpayers should provide bullets to 12-year-olds and then tell them where to go to get a gun in order to protect their constitutional right to bear arms.

Nor will the regulations require any violation of information consent or medical standards. Title X is not supposed to pay for abortion. It is not supposed to promote abortion. There is supposed to be a clear and separate distinction, a wall of separation, between title X and abortion. To talk about abortion to try to get informed consent for abortion is clearly outside of the scope of the program.

Fortunately, when the courts uphold the regulations, the Department of Health and Human Services will be able to clean out the taint of abortion throughout the entire program. That is very much needed. Still, there are other problems with the National Family Planning Program.

As I said earlier, the program rapes the minds of children, undermines family values, and operates without regard to community standards. As an example of this attack on children, there is sex education curriculum funded by title X totally. This curriculum is designed to support homosexual activity. The authors state what the curriculum is and I quote their comments, "A radical approach to sexuality."

The program teaches, if I may quote, "The problem is a homophobic society and his students affirm their sexuality." The author is distressed that society—again I quote from the author of the book—"presents homosexuality as a deviant behavior, a problem similar to the problems of transvestitism or pedophilia, or at best an alternative life-style." Another stated objective is to expose literal hatred of women we believe young men have.

Mr. Chairman, I am embarrassed to quote some of the passages from this book. It is an example of Federal funds being spent without regard to title X statutory requirements. The curriculum states it is unrealistic to expect patients to participate. It is unrealistic and even undesirable in most cases to include patients in the program. That is a conflict with the statute. It is simply outrageous. Tax dollars are going to support militant, homosexual idealogues and Congress should ensure that Federal programs are not involved in these services.

Mr. **Waxman**. Thank you very much.

[Testimony resumes on p. 137.]

[The prepared statement of Jo Ann Gasper follows:]

TESTIMONY OF

Jo Ann Gasper

Hearing on Title X of the Public Health Services

Friday, April 22, 1988

Mr. Chairman, thank you for the opportunity to be here today. I am Jo Ann Gasper, the former Deputy Assistant Secretary for Population Affairs (DASPA), Public Health Service, U. S. Department of Health and Human Services. I served as the DASPA from February 1985 until July 1987. During that time I was responsible for the administration of the Title X National Family Planning Program and the Title XX Adolescent Family Life program. Both programs are authorized under the Public Health Service Act (PHSA). Prior to being appointed the DASPA, I was the Deputy Assistant Secretary for Social Services Policies (DAS/SSP), Office of the Assistant Secretary for Planning and Evaluation (ASPE). As the DAS/SSP I had responsibility for policy oversight for Titles X and XX of the Public Health Services Act. Thus, I have been involved with Title X since 1981. I am here today as an individual expert witness. I do not represent the Executive Branch, in particular the Department of Health and Human Services or the Department of Education, and my testimony has not been endorsed or reviewed by the Administration.

I will be discussing a conspiracy of silence and cover up. Since the program was originally enacted, the administration of Title X has deviated from the law. This lack of compliance with law has resulted in:

- A program which unlawfully promotes, advocates and encourages abortion.
- A program which rapes the minds of children, undermines family values, and operates without regard to community standards.

I will also discuss the choices which Congress can make. It is important that the quality of family planning services be improved and that public confidence in the program be restored. Congress has two basic choices. Congress can either:

- Enact a State Administered Family Planning Program to provide federal subsidies for family planning

or

- Significantly modified the existing categorical program to improve the quality and effectiveness of services.

I will also provide you with my comments on HR 3769.

THE UNLAWFUL OPERATION OF TITLE X

THE CONSPIRACY OF SILENCE

When the National Family Planning Program was originally enacted, Congress clearly intended the program was to help poor women have access to family planning services so that they could plan their pregnancies. Congress wanted family planning services to be readily available to poor women. Congress believed that increasing the availability of family planning services to low income women would in help reduce infant mortality, reduce maternal mortality, and reduce the number of "unwanted" pregnancies. It was felt that reducing the number of "unwanted" pregnancies would reduce the need for abortion. The anti-abortion aspect of Title X was clearly laid out in statute and during the floor debate at the time of enactment. Since its original enactment, supporters of Title X have viewed the program as one which prevents abortion by reducing the need for abortion.

Thorough a conspiracy of silence, Title X has become a program which supports, encourages, and advocates abortion. I was fired by Secretary of Health and Human Services Otis Bowen for refusing to fund abortionists. Secretary Bowen issued a memorandum on February 5, 1987 which directed program administrators to review the eligibility of current and prospective Title X grantees in light of longstanding PHS Grants Administration rules concerning exceptional/advocacy organizations. These rules, at PHS Grants Administration Manual (GAM) Chapter 1:1-05, recognize that grant awards to advocacy organizations can raise special problems, especially when the purposes of the advocacy diverge from or conflict with the purposes of the grant.[1] Although I had requested permission on May 1, 1987, to review two Planned Parenthood organizations because of their abortion advocacy, permission was denied and I was ordered to fund. On June 30 I explained that it would be unlawful for me to fund.[2] I pointed out that if the Department really believed that there was no impropriety in funding abortion advocacy organizations with Title X funds without even a cursory review of their status, then the Secretary, the Assistant Secretary for Health, the Deputy Director or Grants Management Officer for the Office of Population Affairs could be ordered to sign. The grants expired at midnight on June 30 and were not signed until July 2. Signing an expired grant was against the rules. The General Counsel for HHS advised me that if I were to sign the grants after they had expired it would subject me to "wrist slapping" for inappropriate actions and poor management. Thus, the Department actively engaged in a coverup of misuse of federal funds to support abortion and abortion-related activities.

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[1] Although PHS Grants Administration Manual (GAM) Chapter 1:1-05 was revised and reissued on January 7, 1988, all references to the Department's GAM will be for the GAM in effect until January 7, 1988 since these were the rules in effect at the time that the Department improperly funded two pro-abortion organizations.

ABORTION AND ABORTION-RELATED ACTIVITIES

When the National Family Planning Program was originally being debated before the Congress there was a great deal of concern that the provision of family planning services would increase abortion and that the program would encourage and promote abortion. Because of this concern Section 1008 was added to the statute. Section 1008 states:

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[2] Attached is a copy of that memorandum.

> None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning. Based on that language, the Office of General Counsel (OGC) of the Department of Health and Human Services (HAS) has long maintained in numerous legal opinions that:
>
> - there must be a clear and distinct separation between the Title X National Family Planning Program and abortion or abortion-related activities;
> - the National Family Planning Program is not to encourage, promote or advocate abortion;
> - abortion is antithetical to the National Family Planning Program.

Unfortunately, the program has never been administered in strict conformity with law and regulation. In 1982 the General Accounting Office issued a report which clearly showed that clarification of restrictions on abortion and abortion-related activities are very much needed. Questionable activities by the grant recipients which the GAO discovered included:

- A grant recipient was using educational materials which presented barrier methods of contraception together with early abortion in case of failure as a unified method of family planning.[3]
- Through interlocking trustees and the exclusive right and power to nominate and elect trustees, a Title X recipient had effective control of a corporation which

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[3] General Accounting Office (GAO), Restrictions on Abortion and Lobbying Activities in Family Planning Programs Need Clarification, page 11.

operated solely to provide first trimester abortions.[4]

- Abortion clients were counted as family planning clients in the HAS reporting system. Since "productivity" was a factor in the awarding of grants and the amount of funds awarded, abortion clients increased the funding to grantees.[5]

- Counseling practices were not consistent with program guidelines. I want to point out that those guidelines, which are still in effect, are inconsistent with the statute and should be changed. However, the GAO found practices which went even farther than those inappropriately permitted by the guidelines. In general these questionable activities consisted in more pervasive abortion counseling than the specific guidelines allow.[6] Abortion counseling that goes beyond the loose guidelines is clearly contrary to the anti-abortion underpinnings of the program.

- Some clinic practices may have gone beyond "mere referral" for abortion.[7] OGC opinions have stated that

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[4] GAO, page 7.

[5] GAO, page 9.

[6] GAO, page 16.

[7] GAO, page 18.

"mere referral" for abortion is permitted. However, anything more than "mere referral" runs afoul of the statutory prohibitions on abortion.

- Educational materials presented by family planning clinics presented abortion as a backup if a contraceptive method failed.[8]

- All seven Title X recipients reviewed for lobbying had incurred expenses that raised questions as to adherence with Federal statutory restrictions on use of funds for lobbying.[9]

- Grantees used program expenditures for dues to organizations that lobby at the Federal level. One grantee spent over $27,000. The average expenditure was $8,400 per recipient of Title X funds. The use of Title X funds to pay dues to organizations that lobby for or against pending legislation that would affect the grant program is inappropriate in light of current prohibitions against lobbying and the anti-abortion provision within the program's statute.[10]

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[8] GAO, page 20.

[9] GAO, page 25.

[10] GAO, page 25.

As serious as were the problems found by the GAO in 1982, the magnitude of those problem was understated. Staff lawyers from the Office of General Counsel advised me that had the GAO reviewed the program expenditures consistent with the Public Health Service (PHS) policies regarding what is considered program funds and therefore bound by program law and regulations, the findings would have been worse.

The GAO erroneously looked at only the direct individual program dollar. Although this is consistent with accounting practice for some HAS programs such as Medicaid, PHS policy is to regard all program dollars as program funds, whether they are direct federal expenditure or are project "match" dollars. Thus, PHS fiscal policy recognizes a federal part in every dollar spent by the "program".

This will be clearer if I give an example:

Medicaid is a reimbursement program. The state incurs expenses and the federal government reimburses the state a specified percentage of the expenditures. The direct dollars received from the federal government are covered by federal law and regulation. The state match dollars are not covered by federal law and regulation. Within a Medicaid program 55% of the medicaid program dollars will be covered by federal law and regulation and the remaining 45% of the dollars will be bound by state law and regulation. A state thus may use state medicaid funds for abortion which would not be reimburseable because of federal statutory prohibitions.

In contrast, PHS grant policy dictates that program law and regulations cover 100% of every dollar in a program, including the marching funds provided by the grant recipient.

Because some of the funds which the GAO considered as "private" by their accounting standards are in fact program funds under PHS grants policy, the GAO report understated the degree to which the National Family Planning Program was entangled with abortion, abortion-related and lobbying activities.

CO-SITING OF ABORTION AND FAMILY PLANNING

The co-siting of abortion clinics and Title X family planning clinics is probably the most egregious assault on the integrity of the National Family Planning Program. As the GAO has stated, "the public can get the impression that Federal funds are being improperly used for abortion activities."[11] When the GAO reviewed the Title X program in 1982 the estimate of the number of co-sited clinics was 74. That number has grown to 85 in 1986. What is particularly distressing is that the growth in co-siting is in the type of setting which is most troubling for the credibility of the National Family Planning Program. The co-siting of abortion and family planning by Planned Parenthood grant recipients has grown from 21 to 31. The expansion of co-siting in "other non-profits" has been from 4 to 7.[12] Although the overall growth has been 14.9%, the growth of co-siting among Planned Parenthood is 47.6%. Other non-profits increased 75%. Hospitals and Public Health clinics showed declines of 2.2% and 33.3% respectively.

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[11] GAO, page i.

Co-siting of free-standing abortion clinics with federal family planning clinics is clearly contrary to the spirit as well as the letter of the law. Furthermore, it undermines the integrity of the National Family Planning Program. A reasonable man or woman quite easily confuses the federal program with the private program tarnishing the reputation of the federal program.

Because of the manner in which the Department has administered the Title X program, this travesty has been permitted to occur and in fact has expanded. Let me give an example of co-siting of an abortion clinic with a family planning clinic.

The facility operates Monday through Friday. The clinics use the same office space and furnishings, use the same clinic personnel, the same receptionist greets all clients and visitors.

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[12] See Appendix [illegible]: Co-siting.

The only difference is that on Monday, Wednesday, and Friday, all the bills are paid by the federal government and no abortions are performed. Walk through those same doors on Tuesday or Thursday and you have entered an abortion clinic. How is the ordinary citizen to know the difference? The public is not easily able to learn that there are two separate legal corporations. One runs the operations on Monday, Wednesday and Friday. The other corporation is responsible on Tuesday and Thursdays. The husband performs the abortions and is the head of the abortion clinic corporation. His wife is the head of the family planning clinic. All common expenses are pro-rated 60% to Title X and 40% to the abortion clinic because that is the ratio of days of operation. Thus Title X underwrites the expenses of the abortion clinic since such items as medical malpractice, liability and property damage insurance risks are higher for abortion than for family planning. Furthermore, Title X functions as a marketing tool for the abortion clinic, offering free pregnancy tests and reduced rate services. The family planning program can provide the pregnancy test, the gynecological exam, the "options" counseling, and the referral to the abortion clinic. The woman comes back the next day and has the abortion. She is charged for the cost of the abortion procedure and only the abortion procedure. After the abortion the woman is able to return to the family planning clinic for medical follow-up and any family planning services which she may desire, paid for by Title X.

Did Congress intend this entanglement of abortion with family planning? Is this consistent with the longstanding policy that abortion and family planning must be clearly separate and distinct? The resounding answer to both questions is NO. This kind of activity is not consistent with long established Congressional and ostensible DHHS policy.

The co-siting of abortion clinics and family planning clinics results in a situation where the abortion services bulk so large and are so intimately related to the family planning clinic that such a grant is unlawful.[13]

THE PRESIDENT ORDERED HHS COMPLY WITH LAW

President Ronald Reagan ordered HHS to issue regulations to provide guidance to providers of service under the National Family Planning program in order to insure uniform, consistent and strict conformity with the law. Until these regulations are fully implemented, the Title X program will continue to be riddled with the entanglement of abortion and abortion-related activities in clear violation of law.

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[13] OGC has stated that:

> It is recognized that in some situations, the abortion element in a program of family planning services may bulk so large and be so intimately related to all aspects of the program as to make it difficult, if not impossible to separate the eligible and non-eligible items of cost. In such a case, we think a grant for the project would be legally questionable.
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> In other words, a mere technical allocation of funds, attributing Federal dollars to non-abortion activities and other dollars to abortion activities, in what is otherwise a discrete project for providing abortion services, would not, in our opinion, be a legally supportable avoidance of the section 1008 prohibition.

See GAO, pages 13f.

The final regulations, issued February 2, 1988 make a significant step forward to bring program practice into agreement with the anti-abortion policy in law. Although the regulations could go further, they take the minimal steps necessary to remove the taint of abortion from the National Family Planning program. The full and aggressive execution of these regulations will be a significant move to restore public confidence in the program.

The regulations have carefully explained to the public what has been longstanding policy. The National Family Planning program is not to encourage, support, or advocate abortion; and, there must be a clear and distinct separation between abortion and family planning. Unfortunately the policy has not been effectively enforced. Although pro-abortion organizations have complained about the regulations because enforcement of law will mean a significant financial loss to them, the regulations are very good.

There have been some misrepresentations made in the public debate regarding the operation of the program.

First, the Title X program has never been a prenatal program. The program guidelines at 10.1 Prenatal Care state:

"Projects must therefore refer pregnant clients for adequate prenatal care." Prenatal care is permitted only in extremely limited circumstance. Thus, the new regulations will not deny prenatal services to low-income women.

Second, abortion counseling has never been permitted. The program guidelines, which were issued in 1981, require "options" counseling only when a two step test is met. The two step test is: 1) the woman has an unintended pregnancy and 2) that she requests information on her options. [Based upon the number of clinic personnel saying that they have been providing abortion counseling and must continue to do so--unlawful abortion counseling is even more widespread than the GAO determined in 1982.]

RAPING THE MINDS OF CHILDREN

Congress was concerned that the National Family Planning program be operated in a sensitive manner. Since the services which Title X provides are so controversial, Congress, in its wisdom, wanted to make sure that the family was involved and that community standards were not violated.

A recent grant funded by Title X rapes the minds of children. The curriculum is designed to support homosexual activity.[14] The authors of the curriculum state it is a

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[14] Mutual Caring--Mutual Sharing: A Sexuality Education Unit for Adolescents. Developed for the Strafford County Prenatal and Family Planning Program, Dover, New Hampshire.

"...radical approach to sexuality." The program teaches "...that the problem is a homophobic culture." The materials decry a homophobic society and helps students affirm their sexuality. The author is destressed that society "...presents homosexuality as a deviant behavior, a 'problem' similar to the problems of transvestism or pedophilia, or at best and 'alternative lifestyle'." The curriculum is based on conjecture reported as fact. A stated objective is to "...expose the misogyny (literally, hatred of women) that we believe young men have."

It is simply outrageous that tax dollars are going to support militant ideologues.

The statute clearly states that projects operated "shall encourage family participation"[15] and that informational and educational materials developed will be suitable based upon "...the standards of such population or community...". Title X grantees and contractors have disregarded these statutory provisions.

Mutual Caring--Mutual Sharing is an example of grants funded without regard to Title X's statutory requirements. The curriculum states "...it is unrealistic to expect parents to participate....Our working assumption, until we are convinced otherwise, is that it is unrealistic and even undesirable in most cases to include parents in the program."[16]

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[15] Section 1001. [300] (a)....To the extent practicable entities which receive grants or contracts under this subsection shall encourage family participation in projects assisted under this subsection.

The vernacular language used in Mutual Caring--Mutual Sharing is offensive for a school setting and is not consistent with community standards.

Advisory committees are required in order to make sure that both services and information provided are consistent with community standards.[17] Program managers usually form advisory committees which are representative of persons who have received services through a Title X clinic. Frequently, persons who disagree with the program manager are systematically excluded from appointment to advisory committees. Thus, the advisory committees are stacked with persons who represent only one view point and not the community at large.

ABORTION ADVOCACY

Approximately 10 years ago, grants management rules were established which pertained to the funding of "Exceptional Organizations". The rules (PHS.i: 1-05) were reissued effective July 1, 1986 as Chapter VII, Part 700--Exceptional

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[16] Mutual Caring--Mutual Sharing p. 6.

[17] Section 1006 (d) (2) states:
...an advisory committee established by the grantee or contractor in accordance with the Secretary's regulations. Such a committee shall include individuals broadly representative of the population or community to which the materials are to be made available.

Organizations.[18] The purpose of the policy is to ensure that federal funds are awarded to grantee organizations which are competently managed, are responsible, and are committed to achieving the objectives of the grants they receive. As defined by the Grants Administration Manual (GAM):

> An organization may be identified as "exceptional" if it advocates a position or course of conduct in the area for which Federal support is sought based on criteria or views that are not germane to, or conflict with, the purposes of the proposed grant. Examples include applications proposing to explore sensitive matters with political, religious, or moral implications. Special precautions, controls, and close monitoring must be stringently utilized in supporting such proposals [emphasis added].[19]

Organizations which advocate, encourage, or promote abortion as a method of family planning or who have actively sought to expand funding for abortion as a method of family planning clearly hold views in conflict with the Title X statute.[20]

There are special risks associated with funding organizations involved in advocacy activities at conflict with the law. Included among the special risks are:

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[18] Appendix B has a complete copy of Chapter VII, Part 700 -- Exceptional Organizations.

[19] Grants Administration Manual (GAM) 700.2 Definition (b).

[20] OGC has repeatedly maintained that: 1) the family planning program may not be used to promote, encourage, or advocate abortion, 2) there must be a clear and distinct separation between abortion and family planning, and 3) abortion is antithetical to the family planning program.

(i) An advocacy organization may be placed in a government-sponsored position of great influence with persons of special vulnerability.

(ii) A cause which conflicts with the purpose of the grant may be facilitated and given special strength.

(iii) Personnel choices may be made for reasons foreign to the purpose of the grant.

(iv) There may be special motivations to misjudge defaults or deficiencies of participants or to provide special benefits to employees or beneficiaries.[21]

The GAM Exceptional Organization/Advocacy rules require a grant making official to look not only at what is included within the four corners of the grant application but to look at the organization and its activities -- even if those activities are funded by non-Title X dollars. Under the GAM the awarding agency "shall formally assess the sensitive areas..."[22]

The GAM clearly states that:

> If an organization's commitment to its own goals involves the strong likelihood that grant funds may be

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[21] GAM, 700.7 Advocacy Organizations (b) General Considerations.

[22] GAM, (2).

> misused, or if one of the factors in (b)(1) above result, the option of not awarding the grant should be carefully considered [emphasis in original].[23]

The Department has not enforced these rules. The funding of abortion advocacy organizations clearly falls within the scope of the Exceptional Organization/Advocacy rules. A comparison of abortion referrals shows that Planned Parenthood clinics have a significantly higher abortion referral rate than other types of grantee clinics. The sample examined by the General Accounting Office showed the average public clinic referral rate to be 10.2%, while the comparable figure for the Planned Parenthood clinics was 35.2%. The abortion referral rates at the Planned Parenthood clinics ranged up to 86.4%, while the highest rate of referrals at the sampled public clinics was only 20%.[24]

In fact, rather than attempting to enforce the rules, the department has papered over problems in the program. Members of Congress and the public, when they have expressed concern about the funding of abortion advocacy organizations, have been assured by the department that the "projects" are carefully reviewed. In fact, however, the GAM requires that not only the "project" be reviewed but all the activities of the "organization". The Regional Health Administrators (RHAs) who award the service dollars for the National Family Planning Program have told me that they have not and will not look at the abortion advocacy activities of the organization until they have received explicit written instructions to do so. The RHAs are simply following the Department's leadership which has called for the "status quo" in the administration of the National Family Planning Program.

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[23] GAM, (3), page 700-5.

[24] See comparison of referrals made by Title X recipients, attached.

PROGRAM OR PROJECT

Congress prohibited funds going to "programs" where abortion is a method of family planning. The department has administratively interpreted "program" to be synonymous with "project". (A "project" is what is described in the grant application and is typically a part of a larger program conducted by an organization.) Thus, it becomes tautological to say that a family planning program does not pay for abortion as a method of family planning. Programs where abortion is used as a method of family planning simply exclude from their "project" application their abortion activities. DHHS only looks to what is within the grant application and thus will fund the "program" (i.e. project which is part of a large program). The problem of direct conflict with law and Congressional intent, and even DHHS policy, is simply defined away.

A straightforward reading of the statute would indicate that DHHS has contravened the intent of Congress. Section 1008 states:

> None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning.

The Conference Report contains the following statement:

> The legislation does not and is not intended to interfere with or limit programs conducted in accordance with State or local laws and regulations which are supported by funds other than those authorized under this legislation.[25]

A strict reading of the statute and its legislative history would prevent Title X funding of those individual programs operated by an organization where convenience or family planning abortions are performed. The organization could operate other programs, which were not supported by Title X, where abortions were performed and not receive funding unlawfully.

DHHS has used the words "project" and "program" interchangeably. This permits DHHS to bureaucratically manipulate compliance.

Program as used within Section 1008 could be read one of three ways:

1) the discrete project described in a grant application

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[25] Conference Report, H. Rep. No. 91-1667, December 3, 1970, pages 8f.

2) the collectivity of several projects or activities into one individual prospectus

3) the totality of the activities or prospectuses of an organization.

The committee report language appears to exclude the third meaning. The second reading of the word "program" is the most common usage of the word and is the most reasonable interpretation of the statute. The definition which DHHS has used is the most distorted, and permits spurious compliance with the statute.

The GAO has stated that Congress may want to provide guidance to HAS if it does not want Title X funds to go to organizations providing abortions.[26] The Administration has introduced legislation which would clarify that organizations which perform or refer for abortions would be ineligible for funds.[27] Passage of this legislation would expand the current statutory prohibitions regarding funding of program where abortion is a method of family planning. The expansion of anti-abortion provisions does not relieve DHHS of the responsibility to administer the current statute in accordance with the intent of Congress. The excuse that DHHS has not followed the law for 15 years simply cannot be permitted to act as an estoppel to strict enforcement of law and regulation.

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[26] GAO, page 11.

[27] S. 1242 introduced by Senator Humphrey and H.R. 1729 introduced by Congressman Hyde.

PROGRAM GUIDELINES ARE AT CONFLICT WITH STATUTE

Although the law and policy are clear, the Title X guidelines are not consistent with law and regulation. Abortion is antithetical to the National Family Planning Program, yet the guidelines require:

- referral for services related to abortion when the mother's life is not endangered if the fetus is carried to term.[28]
- that grantees engage in "options" counseling when a woman has an unintended pregnancy.[29] It should be remembered that there are only two "options" in dealing with pregnancy--one is birth, the other is abortion. To mandate the discussion of family planning abortions is not consistent with law and regulation.
- endorsement of "postcoital contraception", i.e. the

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[28] Program Guidelines for Project Grants for Family Planning Services (Program Guidelines), pages 7f.

[29] Program Guidelines, 8.6, page 13.

administration of drugs to induce an abortion when unprotected intercourse has occurred around the time of ovulation.[30]

DHHS did make a commitment in August, 1986 to certain members of Congress to bring two areas of the guidelines into conformity with statute. Consistent with this agreement, modifications to 7.4 Referrals and Follow-up and 8.6 Pregnancy Diagnosis and Counseling were developed and cleared through the Office of General Counsel. The cleared guideline changes were never issued. Guidelines, which had been modified to look like a change had been made, were transmitted to certain members of Congress. However, DHHS refused to officially issue guidelines. The proposed guidelines would have made options counseling permissive rather than mandatory; however, if options counseling were provided, all options would be required to be discussed. Furthermore, the change would have removed any requirement for referral for abortion unless the mother's life were endangered if the fetus were carried to term.

DHHS has maintained that committee report language prevents bringing the guidelines into conformity with law and regulation. But Committee report language is not statute. If it were, Congress would not need the President's signature on any law: It could simply write Committee Reports.

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[30] Program Guidelines, 8.4 Fertility Regulation, page 12.

CONGRESS HAS A CHOICE

There are is a basic choice to be made. The National Family Planning Program should become a State Administered program or Congress should make a significant changes in the current categorical program. The enactment of a State Administered program is the best choice.

A STATE ADMINISTERED FAMILY PLANNING PROGRAM

The best way to improve the National Family Planning program and prepare it for the future is to change the program from a categorical program to a state administered program. This would give the states greater flexibility in meeting the family planning needs of the people in their states. States would be able to develop a family planning program which is well received in each respective state. Those states which wanted to have parental consent or notification before a child receives prescription contraceptives could. A State Administered program would permit states to improve coordination of services. Improved coordination would result in increased funds being available from family planning services rather than being spent on administration. In June of 1981 the General Accounting Office stated that $3 million too much was being spent due to the duplication of testing services as family planning clients move between the family planning program and other programs.

Probably most importantly, a State Administer block grant program would enable states to more effectively provide family planning services to a dramatically changing target population. It should be remembered that family planning has historically be targeted primarily to women 15 - 44 years old. This segment of the population will be changing significantly in the future. The effects of demographic changes are already being felt by providers. In order to maintain their client counts, many clinics are providing non-family planning services to women. These non-family planning services which are currently being subsidized by Title X include other health services such as breast cancer screening for older women. Although breast cancer screening for older women is important, it is not a family planning service and should not be subsidized by Title X. With the aging of the population, pressures will continue to be exerted to change Title X from being a family planning program to being a more comprehensive health program.

Let me briefly describe the demographic changes which the family planning program is facing. Although the total population of women 15-44 has increased, it is an older population. Over the years 2/3 of the women served by Title X have been under age 25. In 1970 the age group 15-24 accounted for 42% of the total female population. In 1990, this age group will be just 30% of the total female population. The 15-24 age cohort will have declined by 16% since 1980. Nationally, after increasing by 8% from 1970 to 1980, the female adolescent population has since declined. By 1990 there will be nearly 2 million fewer females aged 15 to 19 than there were in 1980. Today, approximately 1/3 of all title X users are adolescents. Conversely, the 35-44 age group accounted for 27% of the population in 1970 and declined to 25% in 1980. But, the 35-44 age population will increase to 32% of the total female population aged 15-44 in 1990. The older age group is less likely to receive family planning services from organized clinic providers. A State Administered program will be able to much more easily adjust to the graying of the American population.

Enactment of a State Administered Family Planning block grant program would permit Congress to maintain current levels of services and save the administrative costs which would result through reduction of federal staff. Or, Congress could increase dollars available for services without any budget impact by transferring the administrative costs to services. Because of demographic changes, I do not recommend additional increases in funding.

I strongly recommend a State Administered block grant program modeled after the current family planning program with Title X current anti-abortion policies in statute and increased program flexibility.

RECOMMENDED CHANGES TO TITLE X

The following are several areas where Title X could be improved if Congress does not enact a State Administered program. The best way to provide for the provision of family planning services is to enact a State Administered program:

1. The statute should be modified to clearly state that family planning providers should encourage adolescents to abstain from premarital sexual intercourse. Most adolescents are not sexually active. A Lou Harris Poll commissioned by Planned Parenthood shows that only 28% of children aged 12 - 17 have ever had sexual intercourse.[31] Abstinence from premarital sexual intercourse is the most effective, appropriate and healthful manner for children to prevent pregnancy. Abstinence from sexual intercourse is the only family planning method which is 100% effective in preventing pregnancy. Abstinence has no adverse health consequences and is not morally offensive. Furthermore, abstinence prevents the spread of STDs.

2. The statute should be modified to encourage adoption as an alternative to abortion for women and girls with unplanned pregnancies. The original reason that Congress decided to subsidize family planning services was to improve maternal health and reduce infant mortality. When a woman has an unplanned pregnancy, adoption can improve infant mortality by giving women another alternative to abortion. Abortion is inevitably fatal to

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[31] Louis Harris and Associates, Inc., American Teens Speak: Sex, Myths, TV, and Birth Control. Fieldwork: September-October 1986.

the infant.

3. The statute should be modified to require parental consent or notification when a child is given prescription contraceptive services. Girls who are 11 and 12 are utilizing federally subsidized family planning services. Although girls of such an age may not be mature enough to give fully informed consent, they receive prescriptive contraceptive services without either parental knowledge or consent. Parents have a right to know that their child is sexually active in order to encourage responsible sexual behavior. When prescription drugs and devices are used, parents need to know in case there are any adverse health consequences. After all, parents are liable for any medical care which a child might need.

4. The statute should be modified to clearly state that family planning health care providers are required to report to the state child protective service any suspected case of sexual abuse or molestation. Currently sexually active children are receiving services from Title X. Clinic personnel do not report the sexual activity of children to the parents because of the confidentiality provisions in the statute. Some clinic personnel suspect that girls are being sent to Title X clinics for birth control by their pimps. The statute should require that sexually active unmarried children receiving services be reported to the local child protective agency in order to protect the child from sexual exploitation or abuse. Parental notification is the preferred way to prevent child sexual abuse or exploitation.

However, if clinic personnel cannot notify a child's parent, the state child protective agency should receive notification. The child protective agency can then investigate to insure that state laws regarding sexual behavior are enforced and that children are not sexual abused or exploited.

5. The statute should be modified to more clearly state current statutory policy regarding abortion. Section 1008 should be modified to clearly state that the program is not to encourage, promote, or advocate abortion in any way; and, that there must be a clear and distinct separation between abortion and family planning.

6. The statute should be modified to require evaluation. Significant sums of taxpayer money have been spent on providing family planning services, primarily contraceptive service. Currently there is no clear evidence that family planning services reduce sexual activity among unmarried persons or reduce unwanted pregnancies. Pregnancies may not be reduced because the pregnancy reduction of contraception may be more than offset by increases in sex activity. Studies conducted by CDC and the IG show mixed findings. In other words, there is evidence that pregnancy rates increase with increased family planning services and that increases in Title X services increase sexual activity. There are also studies that indicate the opposite. There has not been a full scale independent evaluation of Title X. Proponents and opponents of Title X are able to quote research findings which are equally reliable. After 17 years and billions of

dollars, it is time to find out. Does Title X work? I don't know. The taxpayers deserve to know.

There is a double standard between the program which encourages adolescents to abstain from premarital sexual intercourse (Tile XX) and programs which provide contraceptives to adolescents (Title X). Both approaches have received taxpayer support in order to reduce adolescent pregnancy. The Title XX program has a stringent evaluation to determine program effectiveness. Title X does not require the evaluation of each program. The research which has been done to date on Title X shows inconclusive results.

If Congress is going to continue the Family Planning program, it should know whether or not it works.

7. The statute should be modified to clearly state that Title X funds may not be used to provide contraceptive services, other than the promotion of abstinence from premarital intercourse,at school based clinics. Increasing contraceptive services and information to children has not been demonstrated to be effective in reducing adolescent pregnancy and abortion rates. Although evaluations of School Based Clinics (SBCs) which provide contraceptives or referral for contraceptives have been done, solid data on them are scarce:

o The primary purpose of providing contraceptive services to sexually active adolescents is to prevent pregnancy. It has not been demonstrated that school based clinics have reduced the adolescent pregnancy rate.

- While some clinics have data which indicate a reduction in adolescent birth rates over time, they do not collect the data necessary to assess the effect of services on pregnancy rates.

- This leaves unanswered the question of whether the decline in birth rates is due to a corresponding decline in pregnancy or an increased reliance on abortion.

- Success is often measured by increased utilization of contraceptive services. This raises the question of whether these services are being sought by students who are already sexually active or by those who are contemplating initiation of sexual activity because of contraceptive availability.[32]

When contraceptives are provided to children through the schools, the wrong message is being sent to children. It is far better to develop character in schools than provide contraceptives in school. Eunice Kennedy Shriver's approach to preventing adolescent pregnancy through her "Community of Caring" is far more promising than the mechanical pushing of pills.

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[32] Adolescent Pregnancy and Childbearing.

Particularly in the AIDs era, children need to learn that for their health and well-being there is nothing better than one man-one woman-one family.[33]

9. The statute should be modified to permit for profits to compete to become providers of service. Currently only nonprofit and public entities may provide services under Section 1001. This restriction should be eliminated if Title X remains as a categorical program. Permitting for-profit health care providers to compete would enable the taxpayers to get the most for their money. There is no significant difference in the quality of care which is provided by for-profit and non-profit providers of services. If the Department is permitted to fully compete, the government will be able to benefit from having the most cost effective program.

9. The statute should be modified to clearly state that the income of parents should be counted when providing services to adolescents. Congress has closed loop-holes in the tax laws to prevent children from paying lower tax rates than their parents. Title X should not be subsidizing family planning services for families with the resources to pay for the services. Counting family income, would permit the Title X resources to be

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[33] For a further discussion of School Based Clinics see:
William J. Bennett, "The Case Against School-Based Clinics", Crisis, September 1987.
Tobin W. Demsko, "School-Based Health Clinics: An Analysis of the Johns Hopkins Study", Family Research Council.
Richard D. Glasow, School-Based Clinics, The Abortion Connection, National Right to Life Educational Trust Fund.
Barrett Mosbacker, "Teen Pregnancy and School-Based Health Clinics, Family Research Council.

targeted on low-income families as stated in the law.

10. Modify the statute so that organizations with varying philosophical basis may be eligible to be grantees. Currently certain organizations are not able to apply to be grantees solely due to philosophical differences. An example of this can be seen in groups who support Natural Family Planning but do not support "artificial contraception." These organizations are not eligible to be a grantee. To participate in the program, they must become a sub-contractor to a grantee.

COMMENTS ON HR 3769

Mr. Chairman, HR 3769 has one very useful addition to current statute, "Section 8, Establishment of Requirement of Collection of Certain Data." The information which would be required under this section would be extremely useful. As the DASPA I strongly supported and attempted to improve the data collection for Title X. Certain parts of the PHS have refused to move. I am confident that the current DASPA, shares my views and is probably encountering the same difficulties which I encountered in trying to improve what is known about Title X.

The other proposed modifications to Title X are unnecessary.

Section 4 Train Grants and Contracts I do not understand the difference between what is being proposed and what the Department is currently doing. The training program has been and integral part of Title X. I am unaware of any reason why the training program would not continue as long as there is a categorical family planning program. Should Congress enact a State Administered Family Planning program then training would be left up to each state to determine.

Section 5 Establishment of Grant Program with Respect to Contraception HHS currently has sufficient authority to adequately provide research for the development and evaluation of contraceptives. These authorities are currently administered by NIH. This provision would only duplicate what is already being done.

DHHS currently has an aggressive research agenda to improve contraceptives. There is not a lack of statutory authority for contraceptive research. Furthermore, funding levels are adequate for responsible contraceptive research and development. It is critically important that contraceptive drugs and devices be thoroughly examined and evaluated to insure that the health of women and unborn children not be jeopardized. Research must necessarily move at a pace slower than many would like. The potential damage to women and their children is very obvious. Problems with drugs such as thalidomide and DES, and devices such as the IUD, were not readily apparent. Furthermore, caution needs to be exercised in the development of contraceptives to insure that they are just that -- drugs and devices which prevent pregnancy -- and are not chemical or mechanical methods of destroying innocent unborn children.

Section 6 Research It is unclear what is desired by this amendment. It does not on its face seem to call for new or different activities. Since it does not seem to be different from program practice, it is unnecessary.

Section 7 Information and Education To the extent this initiative is intended to expand contraceptive information and education to children, is also likely to be counterproductive.

Sex education has been available long enough to have numerous evaluations. Although there is a tremendous variety in what is offered in traditional sex education courses, evaluations of these programs have demonstrated:

- some increase in knowledge;
- little impact on values or attitudes;
- mixed results with respect to contraceptive use;
- mixed results with respect to pregnancy rates.[34]

Thus, increasing sex education is not likely to result in changes in values or attitudes needed to encourage children to abstain from premarital sexual relations or to effectively utilize contraceptives if sexually active.

What is more promising is abstinence education for adolescents. Most adolescents are not sexually active and it is better to support and encourage children not to engage in premarital sex. Furthermore, sexual activity rates do not have to continue in an upward trend. Although sexually active rates for adolescents 15-19 have risen from 26.8% in 1971 to 42.8% in 1982, sexual activity rates for black adolescents peaked in 1976 at 62.7 and have declined to 57.8% in 1982. This clearly demonstrates that adolescent behavior can change over time. It also demonstrates that the upward trend of adolescent sexual activity can be reversed.

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[34] Adolescent Pregnancy and Childbearing, Office of Population Affairs, U. S. Department of Health and Human Services.

The Family Life Information Exchange, currently funded by DHHS currently provides information to individuals, and community organizations.

CONCLUSION

DHHS has not administered the Title X Family Planning Program consistent with law and regulation. The department has consistently ignored the law and its own policies. DHHS has refused to provide even minimal guidance to insure reasonable compliance with Title X's anti-abortion provisions. Presidential action was required to improve program compliance with law.

One example of mismanagement and inappropriate activity occurred when I was ordered by Dr. Robert Windom, the Assistant Secretary of Health, to violate a department policy against extending lapsed grants. The reason given me why it was correct to extend expired grants was "Frequently, PHS extends budget periods after the expiration of the project period."[35] This is symptomatic of the disregard for strict enforcement of law and regulation, particularly when it pertains to anti-abortion policies.

Those who ask that the National Family Planning Program be cleaned up and the entanglement and taint of abortion be removed from the program are often tagged as being "anti-family planning" and "extremists". But it is those who promote and encourage the entanglement of abortion and abortion-related activities who are doing an extreme disservice to the integrity of the National Family Planning Program. Title X must be enhanced so that it is a program of family planning services which:

- encourages unmarried children to abstain from premarital sexual relations;
- assists sexually active persons to utilize family planning methods of their own choosing (whether natural or artificial methods);
- helps couples desiring children to achieve that goal through infertility treatment services;

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[35] See Shoe, July 1, 1987 memo, attached.

- supports adolescents and women with unintended pregnancy in considering adoption;

- assists pregnant women to have a healthy pregnancy and a healthy baby.

Only when Title X is purged of all activities and actions which corrupt and poison the program with abortion and abortion-related activities will the National Family Planning Program be what Congress enacted and only then will public confidence in the program be restored.

ESTIMATES OF CO-SITING OF TITLE X CLINICS WITH ABORTION SERVICES

GRANTEE/ DELEGATE	HOSPITAL	PLANNED PARENTHOOD	PUBLIC HEALTH	OTHER NON-PROFIT	TOTAL
REGIONS					
I	6	0	0	0	6
II	9	5	0	2	16
III	4	5	0	1	10
IV	2	3	0	0	5
V	4	2	0	0	6
VI	0	0	0	0	0
VII	1	3	0	0	4
VIII	1	1	0	1	3
IX	18	12	2	2	34
X	0	0	0	1	1
1986 TOTALS	45	31	2	7	85
[1982 TOTALS	46	21	3	4	74]

COMPARISON OF REFERRALS MADE BY TITLE X RECIPIENTS

Clinic type	Records Reviewed	Abortion Referrals[1]	% Abortion Referral
Public:			
City/County	14	-	-
County	13	2	15.4
County	50	1	2.0
County	50	10	20.0
Other nonprofit:			
Planned Parenthood	50	15	30.0
Planned Parenthood	25	1	4.0
Planned Parenthood	50	5	10.0
Planned Parenthood	50	26	52.0
Planned Parenthood	50	21	42.0
Planned Parenthood	22	19	86.4
University	50	-	-
University[2]	-	-	-
University[3]	-	-	-
Private	50	-	-
Total	474	100	4.74

[Analysis based on data provided in "Summary of Referrals Made by Title X Recipients, GAO, page 19]

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[1] Includes only recorded abortion referrals.

[2] Clinic did not offer pregnancy counseling.

[3] No client files reviewed--clinic did not have current contract with title X grantee.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Assistant Secretary
for Health
Washington DC 20201

10:00 A.M., June 30, 1987

MEMORANDUM TO DR. ROBERT WINDOM, ASSISTANT SECRETARY FOR HEALTH

From: Jo Ann Gasper
Deputy Assistant Secretary
for Population Affairs

Subject: Response to Your Memorandum of June 29, 1987 Regarding Extension of Eight Training Grants.

This morning, I executed and transmitted notices of extension for a period of 60 days for six of the eight training grants which have been under discussion since May 1. I did not, and can not, act to extend the other two: Planned Parenthood Federation of America and Planned Parenthood of Wisconsin. To do so would not be lawful.

I want you to know that I did not take this course of action lightly. I do not like situations in which I am forced to act in contradiction to the instructions of my superiors. Nevertheless, this is the only course of action which the law and regulations permit me to take, and I am further strengthened in my resolve by the knowledge that I am acting in full accord with the policies and positions on abortion enunciated many times by my boss, and yours, President Reagan.

The law -- Section 1008 of the Public Health Service Act--states: "No funds appropriated under this title shall be used in programs where abortion is a method of family planning." This has been interpreted by the HHS General Counsel as representing a fundamental programmatic antipathy to abortion.

Departmental rules -- Grants Administration Policies, Chapter PHS.1: 1-05, entitled Exceptional Organizations -- state that, "...program officials shall make every effort to identify exceptional organizations before a grant is awarded, in accordance with the provisions of this policy."

These rules also state that, in the case of advocacy organizations, a category of exceptional organizations, "...the awarding agency shall formally assess the sensitive areas, incorporate appropriate controls in the award document, and provide for close monitoring and appropriate reporting."

These rules also state that if certain factors may result, "the option of not awarding the grant should be carefully considered." Among the factors listed in the rule are: "An advocacy organization may be placed in a government sponsored position of great influence with persons of special vulnerability." and, "A cause which conflicts with the purpose of the grant may be facilitated and given greater strength."

I have been provided information which alleges that Planned Parenthood Federation of America and Planned Parenthood of Wisconsin have taken advocacy positions regarding abortion. In light of this information, I have sought to follow the process established in the Grants Management Rules: 1) determine whether these organizations are indeed advocacy organizations, 2) determine whether their advocacy, if established, would result in any of the factors such as those detailed in the Rules, and 3) determine what controls or safeguards would be appropriate to impose. I proposed to perform this review before taking any action on extension in my memo to you dated May 1. You have refused on numerous occasions to permit me to proceed with such a review.

(I should point out that it is the opinion of the Office of General Counsel, expressed in your presence during a meeting in your office on June 24, that there is no doubt that Planned Parenthood Federation of America and Planned Parenthood of Wisconsin are abortion advocacy organizations as advocacy organizations are defined in the Exceptional Organizations Rules.)

I did not create the Exceptional Organization Rules; they have been in existence for at least ten years. I have merely tried to enforce them. In numerous discussions over the past six months, I have argued to follow established Departmental Rules, and I have been repeatedly instructed to ignore them so that Planned Parenthood can be routinely and painlessly refunded. This I cannot do.

I cannot, in good conscience, award Federal grant funds without being confident of the grantee organization's compliance with all statutes, rules and regulations, particularly where the subject of concern is abortion, which is singled out for prohibitive attention in the Title X statute.

If you really believe that there is no impropriety in funding abortion advocacy organizations with Title X funds without even a cursory review of their status under the Exceptional Organizations rule, you or Secretary Bowen can sign the award documents. If you do not wish to follow this course, the Deputy Director or Grants Management Officer for the Office of Population Affairs could be ordered to sign.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date JUL 1 1987

From Director
Division of Grants and Contracts, ORM/OM

Subject Extension of Title X Nurse Practitioner and General Training Grants

To Chief Counsel, PHS

In accordance with our discussion, it is my understanding that consideration is being given to extending certain Title X Nurse Practitioner and General Training Grants after the expiration of the project periods of these grants.

You have inquired as to the discretion the PHS has to make such extensions subsequent to the expiration of the project period. Frequently, PHS extends budget periods after the expiration of the budget period. In many instances, this occurs after the expiration of the project period. In these cases, the issue date of the award is subsequent to the expiration of the budget or project period. The effective date is always the day after the expired period.

You have also requested advice as to the meaning of the statement contained on page 7 of the PHS Grants Policy Statement that "In no case will such an extension be approved after the expiration date of the final budget period of the project period." This statement applies to extensions requested by grant recipients. A reading of the prior sentence in the Grants Policy Statement makes it clear that the context deals with requests made by grant recipients. The statement does not limit the ability of PHS to initiate and effect noncompeting extensions as contemplated by the preceding paragraph in the Grants Policy Statement which states that "A noncompetitive extension of a budget period or project period may also be initiated by PHS."

Consequently, the administrative policies, including the Grants Policy Statement, which are issued by this office would not preclude the 60-day temporary extensions which you have described to me.

Thomas Shoe

Mr. WAXMAN. Dr. Weed.

STATEMENT OF STAN E. WEED

Mr. WEED. My name is Stan E. Weed. My Ph.D. is in social psychology from the University of Washington, with special emphasis in research methodology, quantitative methods, and data analysis in an applied research context. I am the director of the Institute for Research and Evaluation, a nonprofit research corporation which focuses on social problems and policies related to adolescents, particularly teen pregnancy, drug abuse, delinquency, et cetera.

Because of this focus, today's hearing has particular interest to us since title X programs have been proffered as a solution to the serious social and economic problems associated with teen pregnancy. Title X, of course, addresses other issues, but our intent is to speak to the legislation as it relates to teen pregnancy.

As an institute, we have engaged in extensive study and research in the area of teen pregnancy, examined its social and psychological dimensions, its causes and consequences, and the variety of programs and approaches offered as solutions. We have looked carefully at family life and sex education approaches, family planning approaches, and the more broadly based "enhanced life option" models.

Out of all of this, we suggest some basic criteria by which potential solutions, including this legislation, can be evaluated. Ultimately, it is effective solutions that all of us are interested in. Solutions to problems are like keys to locks. No matter how elegant they are, no matter how well intended they are, no matter how popular they are, if they don't fit, they don't work. We ask that you consider the following as guidelines for developing solutions that fit the problems, that increase the probability of succeeding. Briefly stated, these are as follows:

First, the solution should take into account the stages of emotional, cognitive and social development of the adolescent population. Many of our national and State policies and programs have done this with respect to driving, voting, drinking, contractual relations, et cetera. All of these activities require a certain level of adultlike judgment and responsibility that will minimize risk to self and others. This maturity is directly linked to developmental capacity as well as experience.

Unfortunately, the title X approach for teen pregnancy was a wholesale transition of adult relevant assumptions to an adolescent population where those assumptions were not valid. The extension of a program originally designed to serve poor adult women into the area of teen pregnancy prevention has been both simplistic and overly narrow.

Second, the solution should take into account the significant factors and determinants of adolescent behavior, including their future orientation, their sense of control over their own lives, their belief and value systems, et cetera. More broadly, their sense of identify. Adolescent sexual activity and pregnancy rates are directly related to these internal, psychological dimensions as well as their social context. By not taking these into account, our potential for succeeding is drastically reduced. Title X does not address them.

Third, we must take into account the cultural norms and circumstances, and try to capitalize on the cultural deterrents to pregnancy. As a recent report by the RAND Corp. emphasizes, teenage women who become single mothers and those who avoid pregnancy constitute a highly diverse population. The factors and determinants of adolescent sexual and child-bearing behavior mentioned above vary considerably with that cultural diversity—Moore, Simms and Betsey, 1986; Furstenberg, Brooks-Gunn, and Morgan, 1987. A single-minded, universal solution of contraceptive services to teens has little hope of making a difference.

Fourth, we cannot not rely primarily on the educational/informational approach for changing sexual behavior. Numerous and recent national studies have demonstrated the limitations of the "informational" model as a solution to teen pregnancy. These programs increase knowledge, but have little direct impact on values and attitudes, actual sexual behavior, use of birth control, and teen-age pregnancy. Neither pregnancy education nor contraceptive education exerts any significant effect on the risk of premarital pregnancy among sexually active teenagers.

On the whole, the latest and best research on sexuality education as a deterrent to the problems of teen pregnancy and sexually transmitted diseases indicates that sex education programs as they now exist are not an effective solution. This does not suggest information should not be used. It simply means we can't rely on it to solve the problem, and that it will most likely be helpful only in the context of the other criteria we are proposing here.

Fifth, we cannot simply rely on the medical/technical solution of contraception to solve the problems associated with adolescent sexuality. We have analyzed data for all 50 States and the District of Columbia over a several year period to determine the net effectiveness of family planning programs for teens. We used both cross-sectional and longitudinal data, and controlled for other correlates of teen pregnancy such as poverty, urbanization, mobility, race, prior fertility, et cetera. We found that rather than the predicted reduction of 200 to 300 pregnancies per 1,000 additional teen family planning clients, there were between 40 and 90 more pregnancies, depending on the year.

We did observe fewer births per thousand clients, but also found about 120 more abortions per 1,000 teen clients. The reduction in the birth rate was due not to a reduction in the initial occurrence of pregnancy, but to more frequent termination of pregnancy through abortion—Olsen and Weed, 1986; Weed and Olsen, 1986.

Researchers from the Alan Guttmacher Institute in New York have also found, using similar data, that family planning enrollment rates were associated with lower birth rates, but higher abortion and pregnancy rates. The program assumption that increased availability and accessibility of contraceptive services and counseling would reduce the rate of teenage pregnancy is simply not valid. There is no basis to support the claim of 800,000 averted pregnancies per year.

Sixth, the intervention should focus at the earliest stages of the problem behavior. Family planning providers have explained the program failure by pointing out that teens have usually been sexually active for about a year before they ever come in for services. Our point would be not to encourage contraception at earlier ages, because the developmental capacity limitations mentioned above would simply be greater, and contraceptive failure would increase.

Rather, we would argue for preventive strategies that would delay sexual involvement and experimentation. The AIDS crisis has certainly provided significant incentive for prevention at the earlier stages. Current demonstration programs strongly indicate that it is possible.

Seventh, the approach should be broadly based so that the significant agencies and institutions can provide a mutually reinforced and integrated approach. In particular, it would facilitate the significant and meaningful involvement of parents in the critical events and developmental processes of their children.

A coordinated approach is needed which recognizes the existing and potential impact of a variety of sources of influence in young person's life. Schools, youth services organizations, and other agencies and institutions need to work together in a concerted effort and with a common goal. Without such integration, we should not be surprised to see both wasteful duplication, and significant gaps in essential services as well as ineffective or counterproductive programs.

The potential contribution of parents and families is a much ignored resource in teen pregnancy prevention efforts. It is time for those who profess an interest in parental involvement to seriously consider ways to incorporate parental interests and prerogatives into their programs. Every area of research that has looked at adolescent's acquisition of citizenship, productivity, responsibility, and achievement has identified the major and significant contribution of parental involvement and parental factors. Ignoring, dismissing, or minimizing the role of parents should no longer be tolerated.

Finally, it is essential to assess policy and program effectiveness. The persistence of social problems in the face of continuous funding of social programs requires that we determine what works and what doesn't. If it doesn't work, why not? If it does work, is it cost-effective? Independent and objective evaluation of expensive government programs is a matter of fiscal responsibility and governmental integrity.

In conclusion, the more of these guidelines and factors that we can incorporate into our policies and programs, the more effective and lasting our solutions to the teenage pregnancy problem will be. Unfortunately, the legislation under review here today does not incorporate them adequately, if at all. Whatever title X may do for other segments of the population, what it does not do is contribute to the net solution of teenage pregnancy.

We can ill afford to go another 15 years on the premise that we have a solution that simply needs more money and more time. There is now a substantial body of evidence that was not available to us when title X was initially launched that argues for alternative approaches to teenage pregnancy prevention. These alternative approaches would incorporate the above mentioned guidelines. We need solutions that both work and fit.

Our recommendation would be to reassign the one-third portion for the title X funds currently used for teenage clients and establish a new and different program in line with the criteria listed above that has promise for solving the problem. A second recommendation would be to evaluate more systematically and more objectively, from independent sources, not only this new thrust but the existing title X programs that have operated on untested assumptions.

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Mr. **Waxman**. Mr. Schwartz.

STATEMENT OF MICHAEL SCHWARTZ

Mr. **Schwartz**. While Americans are bitterly divided over the legality of abortion, one point on which virtually everyone agrees is that it is better to prevent unwanted pregnancies than to end them through abortion. As a matter of public policy, government agencies and grantees offer family planning services to all who want them as a means of reducing the need for abortion. Teenagers have been a primary target of these programs.

The rapidly increasing rates of pregnancy, abortion and out-of-wedlock births among teenagers have generated widespread public alarm over unwanted teenage pregnancy. The response has been more intensive efforts to involve teenagers in family planning programs.

In 1970, there were approximately 330,000 family planning clinic clients under the age of 20. Vigorous promotion of clinic programs for teenagers by Federal, State, and local agencies boosted enrollment rapidly throughout the 1970's so that by 1980, teenage enrollment in clinic programs peaked at 1.7 million. Despite declines in the teenage population since then, clinic enrollment among teenagers still stands above 1.5 million.

The fivefold expansion of clinic programs for teenagers was clearly the major factor in the increase in contraceptive use observed by Kantner and Zelnik in their three NIH-funded surveys of sexual activity, contraception and pregnancy among American teenagers in 1971, 1976, and 1979.

In their 1971 survey, Kantner and Zelnick found that fewer than 20 percent of sexually active teenagers were always-users of contraception. Fewer than half had used a contraceptive at last intercourse and fewer than one-seventh used medical methods of contraception, the most popular methods being condoms and withdrawal.

Five years later, after Federal family planning efforts had been geared up, they found that more than 30 percent of the sexually active teenagers were always-users; almost two-thirds had used a contraceptive the last time they had intercourse; and one-third were users of medical methods. By 1976, oral contraceptives had become the most popular method of contraception among teenagers.

In light of this significant qualitative and quantitative increase in contraceptive use among teenagers, it cannot be doubted that the family planning clinic programs had achieved their initial goal of promoting more widespread use of contraception by sexually-active teenagers.

Yet, as "Family Planning Perspectives" ruefully reported in 1980, "Most teenagers are using contraceptives and using them more consistently than ever before. Yet the number and rate of premarital adolescent pregnancies continues to rise."

The increase in teenage out-of-wedlock pregnancy during the 1970's was enormous. The combined number of abortions and out-of-wedlock births among teenagers nearly tripled during the decade, even as the number of teenagers enrolled in family planning clinic programs increased fivefold.

The evident failure of the clinic programs to stem the increase in premarital teen pregnancy brought forth strong criticism of the family planning program. At a 1981 Senate hearing, opponents of the program noted that clinic expansion was associated with higher rather than lower teen pregnancy rates. This effect, they argued, was due to (a) the relatively high pregnancy rate among teenage contraceptive users, a pregnancy rate actually higher than the rate of unintended pregnancy in the overall teenage population, and (b) the far higher rates of sexual activity among teenagers which, they claimed, had actually be caused in part by the clinic programs themselves, through their implied approval of premarital intercourse.

In support of this view, opponents of the programs cited the close correlation between rates of increase in expenditures and enrollment of teenagers in the clinic programs and the rate of increase in premarital pregnancy among teenagers; and the observation that the proportion of sexually active teenagers who became premaritally pregnant remained remarkably consistent—at approximately 30 percent, despite the acknowledged increases in contraceptive use.

Defenders of the programs responded to this criticism by accusing their attackers of a post hoc ergo propter hoc fallacy. It was true, they acknowledged, that premarital pregnancy was increasing, but those increases might have been far more rapid without the family planning clinic programs.

Kantner and Zelnik had made a crude attempt to estimate the quantitative impact of family planning programs on teenage pregnancy rates. They multiplied the pregnancy rate of sexually-active never-users of contraception by the entire sexually active teenage population to determine the hypothetical total of teen pregnancies if no contraceptive programs existed.

From this figure, they subtracted the actual number of teen pregnancies in 1976 and concluded that some 680,000 teen pregnancies had been averted through contraceptive use in that year. Reversing the same procedure, they multiplied the pregnancy rate of always-users of contraception by the same estimated total of sexually active teenagers, and concluded that if all of those teenagers had been always-users of contraception, an additional 313,000 pregnancies might have been averted.

These facile computations did serve to illustrate the uncontested point that sexually active teenagers were four to five times less likely to get pregnant if they always used contraception than if they never used contraception. As a realistic assessment of the impact of family planning programs on teenage pregnancy, however, they were vulnerable to the charge that they failed to account for the major argument of program opponents; namely, that the programs themselves had an impact on the rate of premarital sexual activity among teenagers.

A more sophisticated defense of the effectiveness of the programs was needed, and it was supplied in a 1981 study by Forrest, Hermalin, and Henshaw for the Alan Guttmacher Institute. These researchers carried out a multivariate correlation analysis between teenage enrollment in family planning clinic programs and the teenage birth rate in selected counties. Using five distinct regression models, they ultimately determined that in 1976 the effect of the enrollment of 1,000 teenagers in family planning clinics was a reduction in the number of births to teenagers by 94. The total number of births averted as a result of the clinic programs in 1976 was estimated, on this basis, at 119,000.

The methodology of the AGI research team in reaching this figure is open to serious question. Of the five regression models they used, only one yielded results highly favorable to the programs, and this one applied the rate of sexual activity—the very point of controversy—as a control variable.

Moreover, since sexual activity could not be measured directly, it was estimated, in part, on the basis of the birth rate. Consequently, their adjusted birth rates were adjusted, in part, by the birth rates themselves. This was only the beginning of the mathematical difficulties connected with this AGI report.

The authors went on to note that live births represented only a portion of the total number of unwanted pregnancies that occurred among teenagers. In 1976, only 36 percent of unintended teenager pregnancies ended in live birth. Therefore, reasoned the AGI research team, the live births averted by the family planning clinic programs must represent a similar number of the total proportion of unwanted teenage pregnancies averted by those programs. Based on that assumption, they estimated that family planning clinic programs were responsible for averting 172,000 abortions and a total of 331,000 pregnancies in 1976.

Extrapolating these results through the entire decade, the researchers claimed that nearly 1 million births and 1.4 million abortions had been averted as a result of the family planning clinic programs.

These results were widely cited as evidence of the effectiveness of the programs. Despite the continuing increase in the actual rate and number of out-of-wedlock pregnancies among teenagers, there was plausible mathematical support for the contention that the situation would be even worse if not for the family planning clinics.

The AGI results were not universally accepted. For one thing, the researchers made no distinction between marital births and out-of-wedlock births, even though the demographic trend of the 1970's showed that these two categories of births were moving in contrary directions. Out-of-wedlock births to teenage mothers had steadily increased during the decade, rising from 190,000 in 1970 to 260,000 in 1980. This increase was more than offset by the steady decline in births to married women under the age of 20, from 450,000 to 280,000.

This reduction in the number of births to married women was the result of two major factors: an increase in the average age of marriage, which reduced the pool of married teenagers, and the general decrease in fertility among married women. The birth rate for those married under 20 declined at approximately the same rate as that of older married women, but the net effect of this sharp decline in marital births to teenage mothers was to offset the increase in out-of-wedlock births to teenagers.

On balance, teenagers gave birth to far fewer babies in 1980 than in 1970, but this fact tended to disguise the actual increase in those out-of-wedlock births which constitute a serious social problem. If the AGI study had distinguished between marital and nonmarital births, the results would have shown a worsening rather than a improvement in the situation.

A more serious criticism was that averted births was an inadequate basis for inferring averted pregnancies or abortions. A majority of unintended teen pregnancies ended in abortion, and abortion was obviously a major factor in averting births in this age group. But while an abortion can avert one live birth, it cannot also avert 1.4 abortions. The irony of the AGI analysis is that it inferred averted abortions from birth statistics that were themselves depressed by higher abortion rates.

The earlier criticism of the effectiveness of the programs, based on the continuing increases in abortion and out-of-wedlock birth rates among teenagers, was not conclusive because it failed to establish a casual link between clinic enrollment and lower birth rates was at least equally inconclusive. Even leaving aside the problematic character of the allegedly averted live births, the inference from averted births to averted pregnancies is painfully invalid.

A newly released study by Stan Weed and Joseph Olsen of the independent Institute for Research and Evaluation breaks this impasse. Weed and Olsen used essentially the same sort of multivariate regression analysis employed by Forrest, Hermalin and Henshaw. But they gathered statistics from all 50 States and the District of Columbia, instead of merely from selected counties. And, instead of relying on mathematically shaky inferences of how many abortions must have been averted as a result of a certain number of averted births, they calculated the correlations of clinic enrollment with abortions and pregnancy as well as with live births.

Weed and Olsen, like the AGI research team, did not distinguish between marital and nonmarital pregnancies and births. This is so, in part, because many of the data-collecting agencies do not so distinguish, and in part because Weed and Olsen wished to replicate, as closely as possible, the methodology of the earlier researchers. Consequently, their study is open to the same criticism as the AGI study in this respect. It cannot be determined with certainty, but it is highly probable, on the basis of the contrary trends of marital and nonmarital births among teenagers, that this conflation of the marital and non-marital statistics tend to exaggerate the positive impact of the clinic programs in both studies.

The Weed-Olsen study agreed with the AGI analysis in finding a relationship between clinic enrollment and lower teen birth rates, although they generally found a smaller magnitude of birth reduction than the earlier study had. For 1980, for example, Forrest, Hermalin, and Henshaw estimated that 79 births were averted for every 1,000 teenagers enrolled in family planning clinic programs. For that same year, but using statistics from the entire Nation, Weed and Olsen calculated 77 averted births per 1,000 clinic clients.

For 1978 the disparity between the two studies was even greater, with the AGI researchers projecting 101 averted births per 1,000 teenage clients, and Weed and Olsen finding only 40 per 1,000.

Nonetheless, both studies conclude that clinic enrollment is associated with lower teenage birth rates, despite their differences in estimating the magnitude of those reductions. With this agreement, however, the similarity between the two studies ends. Weed and Olsen confront with hard data the inferences of the AGI team regarding allegedly averted abortions among teenagers as a result of clinic enrollment.

Where the AGI researchers had projected 146 fewer abortions per 1,000 clinic enrollees in 1978, Weed and Olsen found 130 more abortions. For 1980, the AGI team had projected 169 fewer abortions, but Weed and Olsen found 123 more abortions.

These are dramatic differences, pointing to absolutely contradictory conclusions. If the AGI analysis is to be believed, then family planning clinic enrollment is associated with substantially reduced abortion rates. The AGI researchers go so far as to make the claim that clinic programs have actually averted millions of abortions. But they make this claim without counting a single abortion, without making the slightest effort to determine whether the lower birth rates which they had noted were a cause or an effect of changes in the abortion rates.

Weed and Olsen's estimates were based on actual calculations of correlations between clinic enrollment and abortions, not on mere inferences from averted births. They demonstrate conclusively that all of the reduction in births to teenage mothers associated with clinic enrollment are the result of the higher abortion rates associated with clinic enrollment. Not only that, but the increase in teenage abortion rates associated with clinic enrollment is so large that it points to an actual increase in the teen pregnancy rates associated with clinic enrollment. Weed and Olsen have demonstrated that abortion has been a cause and not an effect of averted teenage births.

What do these results say about the effectiveness of family planning clinic programs in reducing the level of unintended pregnancies among teenagers, which, after all, is their objective?

In both 1978 and 1980, according to the AGI projections, family planning clinic programs were responsible for averting 282 pregnancies for every 1,000 teenagers enrolled. On the basis of those projections, the programs reduced the number of teen abortions by upwards of 200,000 a year. These would be impressive accomplishments—but the Weed-Olsen study shows that they are totally illusory.

According to the findings of Weed and Olsen, family planning clinic enrollment was actually associated with an increase rather than a reduction of teenage pregnancy. They found 95 additional pregnancies per 1,000 teenage clinic clients in 1978 and 42 additional pregnancies per 1,000 in 1980.

According to the findings of Weed and Olsen, the enrollment of teenagers in family planning clinics is associated with lower teen birth rates, but not with lower pregnancy rates. All of the reduction in the birth rates is attributable to the substantially higher abortion rates, while the rate of pregnancy among teenagers is actually found to increase in connection with family planning clinic enrollment.

The implication of this analysis is that family planning clinics do not reduce pregnancy rates among teenagers, but tend to increase those rates. Weed and Olsen do not speculate on the reason for this anomalous effect, because their study was empirical. But their findings do lend support to the argument of earlier critics that the existence of these programs tends to elevate rates of premarital sexual activity among teenagers, thereby exposing more teenagers to the risk of pregnancy.

Even more significant is the startling increase in teenage abortions which Weed and Olsen found to be associated with clinic enrollment. It is clear that the reductions in teen birth rates associated with family planning clinic enrollment are not primarily the result of averted pregnancies but of substantially increased abortion rates.

According to the findings of Weed and Olsen, the major impact of family planning clinics among their teenage clients is not to reduce the pregnancy rate but to reduce the rate of continuation for pregnancies, that is, to increase the abortion rate. This effect is so substantial that nearly half the abortions performed on teenagers can be attributed to the impact of family planning clinics.

Supporters of family planning clinics have depended on the claim that the services of these clinics reduce the need for abortions among teenagers. But Weed and Olsen have demonstrated that precisely the opposite effect is produced by the clinic programs. Far from reducing the demand for abortion, they create a market for abortion among teenagers by leading to higher pregnancy rates and by discouraging continuation of pregnancies.

If family planning clinic programs did not serve teenagers, there would be approximately 125 fewer abortions annually for every 1,000 teenagers currently enrolled. The number of abortions would decline by about 200,000 a year.

Weed and Olsen do not speculate on the cause of the higher teen pregnancy rates associated with family planning clinic enrollment. The matter is not really a mystery, however. Several factors can be isolated from the current literature on the subject which explain why the programs do not yield the desired effects.

First, contraceptive use reduces, but does not eliminate, the likelihood of pregnancy among teenagers. According to a life-table developed from the 1976 data of Kantner and Zelnik, sexually active teenagers who never used a contraceptive method have a 48.6 percent chance of becoming pregnant within 1 year of their first intercourse, and a 65.9 chance of becoming pregnant within 2 years. Among those who used a medical method of contraception, the pregnancy rate within 1 year of first intercourse is 7.9 percent and within 2 years it is 13.6 percent.

Thus, even if all never-users became users of medical methods of contraception, there would still be about one-fifth as many pregnancies. This, however, is a comparison between two extremes—those who are sexually active but never use any form of contraception and those who used the best contraception available. Real-life behavior generally falls between these two extremes. The actual experience of sexually active teenagers in 1976 is that 22.2 percent became pregnant within 1 year of first intercourse, and 34.8 percent within 2 years. This means that if all sexually active teenagers used medical methods of contraception, the pregnancy rate would still be one-third to one-half as high as it currently is among sexually active teenagers.

Contraception is certainly not totally ineffective. A woman is less likely to become pregnant while using contraception than she is if she experiences unprotected intercourse. But a reduction of the possibility of pregnancy is a far cry from the elimination of that possibility, so far that a substantial majority of unintended pregnancies among teenagers occur among contraceptive users, and about one-third of those pregnancies occur while a contraceptive is being used.

Thus, the alternative "protected or pregnant" is simply not valid. A substantial percentage of those young women who think they are protected, almost one-fourth within a year, become pregnant anyway.

Second, enrollment in a family planning clinic program does not necessarily translate into regular contraceptive use among teenagers. A study conducted in 1980 and 1981, involving 445 adolescent clients at nine federally funded family planning clinics in the Philadelphia area, found that at the end of 15 months, only 82 percent of the responding clients were currently using contraception, but only 43 percent had been always-users during that time period.

In addition, about one-third of the initial sample was lost to followup, so the actual contraceptive continuation rate for the entire sample may have been lower. The researchers were able to identify certain factors associated with higher continuation rates. Among these were age, high academic performance, and greater frequency of intercourse.

Third, family planning clinic enrollment and contraceptive use are associated with more frequent intercourse. This has been noted repeatedly in studies of adult and adolescent women. In one survey of teenage clients at a large Michigan family planning clinic, for instance, the average frequency of intercourse increased by more than 50 percent within 1 year of clinic enrollment.

If the risk of pregnancy over a given period of time is understood as the product of the pregnancy risk at each act of intercourse times the frequency of intercourse, it will be seen that this increase in the frequency of intercourse tends to diminish the positive effect of contraceptive use.

For the overwhelming majority of teenage girls, their first act of intercourse is unplanned and regretted. It is typically followed by a stage of denial and by a fairly long lapse of time between first and second intercourse, for those who experience intercourse a second time. Kantner and Zelnik found in 1976 that 14 percent of all the teenage women classified as sexually active; that is, nonvirgin, had experienced intercourse only once.

On average, this lapse of time is 3 months, although it is longer for younger girls and shorter for older ones. According to Constance Lindemann, one of the objectives of a family planning counselor in dealing with a new teenage client is to help the client overcome her feelings of guilt and ambivalence about her sexual activity. Eliminating such feelings is a motivation to more conscientious contraceptive use. But it is also, inevitably, a motivation for more frequent intercourse.

Fourth, clinic enrollment tends to discourage secondary virginity. There seems to be an insufficient appreciation of the fact that sexual activity is not an addictive behavior, and that many young women who are not virgins may not be currently sexually active, and hence not at risk of pregnancy. In the Philadelphia study, one of the reasons cited for contraceptive discontinuation was the breakup of a steady relationship or some other factor leading to a temporary or permanent discontinuation of sexual activity. This is not an uncommon phenomenon, although it has not received detailed scholarly study.

In Kantner and Zelnik's 1976 study, half the sexually active women had not experienced intercourse in the month preceding their interview. Presumably, a substantial proportion of these young women had no intention of having intercourse again until they were much older. They had resolved their feelings of guilt and ambivalence through a decision not to resume a sexually active behavior pattern. Although they were categorized as sexually active, they were at zero risk of pregnancy until such time as they resumed sexual activity.

This factor is the most likely explanation for the surprising low pregnancy rate among nonusers of contraception, especially in the second year after first intercourse. If all noncontraceptors had intercourse as frequently as contraceptive users, their pregnancy rate within 1 year would probably be over 80 percent. Infrequent intercourse and secondary virginity contribute significantly to holding down pregnancy rates among unmarried teenagers, perhaps as much as contraceptive use does. Yet this is a safety factor which is not enhanced, but counteracted by the activities of family planning clinics.

As a consequence of these four factors, which work to offset the anticipated reductions in pregnancy rates produced by improved contraceptive use, the proportion of sexually active teenagers who have experienced a pregnancy has remained remarkably steady at about 30 percent. In four separate, large-scale studies of teenage sexual behavior and contraceptive use from 1971 to 1982, the proportion of sexually active teenagers who had experienced a pregnancy never deviated by more than 2.5 percent from this 30 percent figure. This consistency is especially striking in view of the sharp changes in the rates of sexual activity and of contraceptive use reported in those same studies.

On balance, then, efforts to improve contraceptive use among teenagers have simply been a wash with respect to reducing pregnancy rates among those who are sexually active. For every step forward in reducing teenage pregnancy through more widespread, more regular and more sophisticated contraceptive use, there has been an equivalent step backwards due to more frequent intercourse and the high rate of contraceptive failure.

But the programs have not been neutral in their impact on the overall levels of premarital teenage pregnancy.

The proportion of births to teenage mothers that are out-of-wedlock has increased enormously. The Center for Disease Control estimate that 46,000 abortions were performed on teenagers in 1970. The Alan Guttmacher Institute estimates a figure about twice as high. By 1980, the number of abortions performed on teenagers had peaked at nearly 450,000, and it has remained over 400,000 ever since.

Yet it would not be precisely correct to say there has been a great increase in teenage pregnancy during this period. The overall teen pregnancy rate increased only modestly since 1970. But there has been a tremendous increase in out-of-wedlock pregnancy among teenagers, up from about 300,000 in 1970 to more than 750,000 by 1980. This is the social problem that has been identified as teen pregnancy.

Those pregnancies that result in a marital birth to a woman under 20 are simply not a problem for the public. They are declining in frequency and, in any case, do not represent a pathological social situation. Pregnancies that end in out-of-wedlock births or in abortions are a problem, at any age, and the gigantic increase in this social pathology among teenagers is cause for concern.

The increase in premarital pregnancy among teenagers is obviously a result of an increase in premarital sexual activity. Such a complex phenomenon cannot be attributed to any one single cause, but one factor which clearly emerges as a contributing cause has been the more widespread availability of family planning services for unmarried teenagers. The following chart illustrates the correlation between family planning clinic enrollment and sexual activity and its consequences among teenagers.

Obviously, the cause of the increases and decreases in the total numbers of out-of-wedlock pregnancies and births and abortions is the proportion of unmarried teenagers who are sexually active. A more significant question is whether the rate of sexual activity is a cause or consequence of the enrollment of teenagers in family planning clinic programs.

Throughout the 1970's there was a steady and sharp increase in both of these measures, followed by a slight decline in the early 1980's. But the decline in family planning clinic enrollment was not a response to a reduced demand for such services produced by a decline in the rate of sexual activity. The cause of the enrollment decline was a reduction in the funding of title X, from $161.7 million in fiscal year 1981 to $124.2 million in fiscal year 1982. This strongly suggests that declines in clinic enrollment of teenagers causes declines in the rate of sexual activity, rather than vice-versa. This suggestion is reinforced by the differences in the age-specific rates of sexual activity between 1979 and 1982.

The reduction in the rate of sexual activity was more pronounced in younger age cohorts than in older. An obvious reason for this is that high levels of sexual activity had already been established within the older age cohorts who had been exposed to the impact of larger family planning programs. The age-specific rates of sexual activity among younger teenagers in 1982 were very close to those of 1976, when the level of family planning clinic enrollment was approximately the same as it was in 1982.

If the funding levels of family planning programs had remained the same or declined further after 1983, instead of increasing again, it is likely that the number of out-of-wedlock pregnancies, births and abortions would have continued to decline instead of inching back upwards, as the reductions in clinic enrollment would have had time to effect a substantial reduction in the rate of premarital sexual activity.

These observations agree with those of Weed and Olsen. Increased funding of family planning programs produces higher levels of enrollment among teenagers, which produces higher levels of sexual activity among unmarried teenagers, which produces higher rates of out-of-wedlock pregnancy, which leads to higher totals of abortions and out-of-wedlock births. On the other hand, reductions of funding in family planning programs produce lower enrollment among teenagers, which lead to lower rates of premarital sexual activity, and hence lower abortion and out-of-wedlock birth totals.

This conclusion seems paradoxical in view of the purpose of family planning programs; namely, to reduce the levels of unintended pregnancy through improved contraceptive use. But is has already been observed that changes in contraceptive practice do not have a significant impact on the percentage of sexually active teenagers who become pregnant. Since the other effect of increased funding of family planning programs is to increase the percentage of teenagers who are sexually active, and hence at risk of pregnancy, it follows that increases in family planning expenditures lead to increases rather than decreases in the unintended teen pregnancies they are intended to reduce.

Mr. **Waxman**. Thank you.

Mr. Glasnow.

STATEMENT OF RICHARD GLASNOW

Mr. **Glasnow**. I am Richard Glasnow, director of education for the National Right to Life Committee [NRLC].

The National Right to Life Committee is the Nation's major prolife organization. We represent about 2,500 local prolife chapters. We are advocates for those innocent human beings whose right to life is threatened by abortion, infanticide, or euthanasia.

NRLC and its affiliates take no position whatever on contraception, properly so-called. Our members have views that run the gamut on the issue of contraception. We recognize, however, that title X is currently a major source of funds for certain organizations which treat abortion as simply one birth-control option among many.

NRLC has many concerns with the way that title X has been implemented over the years. Most of those concerns will be addressed by other witnesses here today. Therefore, I shall concentrate on two new concerns about the proposed amendments to title X in H.R. 3769, which would promote abortion in two ways: funding of so-called school-based clinics, and research and development of abortion-causing drugs and devices, such as the abortion pill, RU 486.

School-based clinics promote abortion counseling and referrals, pro-abortion education and abortion pills.

First, section 5 of H.R. 3769 to fund a "grant program with respect to information and education" is clearly intended to pour Federal title X dollars into school-based clinics [SBC's]. The connection between the proposed amendments to title X and SBC's was acknowledged last July by a spokesman for the pro-abortion National Family Planning and Reproductive Health Association—the trade association and lobbying arm of the family planning industry.

In a story in the Washington Post on Wednesday, July 29, 1987, Scott Swirling, executive director of the association, stated that the bill would indeed fund school-based clinics. His exact words were: "It is not the case that new research money would be going to abortion-causing drugs, nor is the bill intended solely to fund school-based clinics."

H.R. 3769 would authorize title X funding for SBC's, and if a SBC received any title X funds, the staff would be required—under the present guidelines governing recipient policies—to provide abortion counseling and referrals behind parents' backs, even over the objections of local officials.

Unfortunately, many policymakers and members of the public have unthinkingly accepted claims that SBC's do not promote abortion. Illustrative of the assurances routinely given the public was the statement that appeared in the Los Angeles Daily News attributed to Jackie Goldberg, the Los Angeles school board member who coauthored the proposal which established two clinics. "We don't intend to have an abortion referral service in the clinic," she said. "It's really sad how a good idea can be ruined by going around and yelling abortion," she lamented.

These claims are at best half-truths. Clinic supporters recognized several years ago that their pro-abortion policies and activities posed a potentially significant public relations problem. In an important article published in March 1985 summarizing SBC activities, Joy Dryfoos observed that "the issue of abortion is frequently finessed in these clinics." This choice of words and the description of SBC policies found earlier in her article would alert the reader that SBC staff members are indeed employing a "subtle and tactful strategy"—to quote the dictionary definition of "finesse." By being less than candid, SBC proponents were able to achieve their objective of arranging for abortions without arousing the indignation of either the parents or community.

The careful reader will find in the speeches and publications of SBC proponents explaining clinic activities clear evidence that SBC's currently encourage abortion in two ways. First, school-based clinics exploit the authority of the schools to funnel a captive clientele of pregnant teens into abortion mills without parental knowledge or consent. Second, clinic staff members teach pro-abortion "sex education."

In addition, the widespread establishment of SBC's could have dangerous future implications. Critics fear that if SBC advocates are successful in carrying out their plans to open clinics throughout the country, the facilities could become distribution centers for the abortion pill, RU 486, if it eventually reaches the market in the United States.

The principal prolife objection to school-based clinics is that they counsel and refer pregnant girls for abortions. In this section, we will explain what those terms mean. We will also offer evidence from speeches and publications by leading SBC advocates and staff members to demonstrate how school clinics, either openly or covertly counsel and refer for abortions.

Another term figuring prominently in this discussion is "performing" or "providing" abortion which means the intentional killing of the unborn child either by dismembering the baby by sharp instruments or by injecting toxic chemicals. At this writing, no school-based clinic performs abortions. However, some organizations which sponsor school-based clinics do. For example, the St. Paul-Ramsey Hospital Center in St. Paul, MN, which operated several of the most widely emulated SBC's from 1973 through 1986, performs both first and second-trimester abortions.

Defining counseling and referral: Defining terms is an essential first step in this controversial public policy debate because the SBC advocates will sometimes give an erroneous impression of what services a clinic is performing by twisting the usual meaning of words, especially the terms "counsel" and "refer."

"Counseling" by SBC's means informing the pregnant girl about her "legal options," abortion or birth, and assisting her in making a decision about what course of action to take. Counseling is usually conducted in conjunction with a laboratory test and a physical examination to confirm pregnancy (U.S. Department of Health and Human Services 1981; 3,10,12,13).

One of the key pieces of information provided to a pregnant girl during counseling is the fact that she has the constitutionally protected right to obtain an abortion without her parents' knowledge or consent. While some States require nominal parental notification or consent, the U.S. Supreme Court has ruled that the girl can bypass her parents by going before a judge. (Morrissey 1986, 68-69.)

SBC staff members either counsel pregnant girls in their own clinic, or if prohibited from so doing, refer the teens to an outside organization who will counsel the girl, including telling her about the option of abortion.

"Referral," thus, describes the process of sending the girl to an agency outside of the school to obtain services that the SBC does not provide. (U.S. Department of Health and Human Services 1981, 7-8, 13). The staff refers the girls out when the SBC either does not want to provide a certain service itself—such as performing abortions—or is prohibited from providing a service—such as being involved with abortion-related activities.

In addition to referring for counseling, SBC's also refer for abortions—either directly or indirectly. When the rules permit, SBC's will refer pregnant teenage girls directly to an abortion provider in the community. Right-to-life advocates usually connect the word "referral" solely with this type of activity since the national family planning industry operates in this way. This referral might consist of giving the girl the name and location of the abortionist, directions to the office, the hours of operation, and information about possible sources of funding for the abortion, such as Medicaid or loans.

An example of this appeared in a story in the New York Times on October 15, 1986. It explained how Fran Combe, the resident nurse practitioner in the clinic located in Martin Luther King, Jr. High School in Manhattan, made seven abortion referrals during one school year (Perlez 1986). According to the Times, 5 of the 10 girls who were found to be pregnant at Combe's clinic had abortions at the Eastern Women's Center, the abortion clinic at 14 East 60th Street that she most frequently recommends. Combe also directed two other pregnant girls to another abortion facility. The remaining three young women had their babies.

The second scenario occurs when the SBC staff is prevented by regulations or school policies from offering counseling and direct referrals to abortionists. In this case, they arrange what we will call an "indirect" referral for those abortion-related services. The school clinic circumvents the restrictions by sending the pregnant girl to an agency outside of the school, which is not governed by the same restrictions, such as the local Planned Parenthood, city or State public health clinic, or public hospital. There she could obtain a confidential pregnancy test, counseling about abortion, and another referral by the community-based agency to an abortionist—an abortion provider. As we shall see, SBC staff have persuaded themselves that this type of indirect referral does not violate school or parental restrictions on abortion-related activities.

SBC's allowed to perform abortion counseling and direct referrals: According to SBC proponents, the laws and regulations governing a school clinic's operations determine what type of arrangements the staff makes to guarantee that pregnant girls can obtain abortions confidentially. We will initially examine two sets of reasons SBC's which perform on-site abortion counseling and direct referrals to abortionists without parental knowledge or consent. This section will also point out the flaws in the SBC proponents' flimsy justifications for their abortion counseling techniques. Then we will turn our attention to how the school-clinic staff utilizes indirect referrals to achieve the same objectives. There are no published statistics revealing how many SBC's take either approach.

Federal and State requirements said to mandate abortion-related activities: Some SBC's justify performing controversial abortion-related activities in their own facilities on the grounds that they are obligated to do so by either State or Federal law.

For example, the October 1986 issue of Clinic News, published by the Center for Population Options' clinic support center, listed 33 States and the District of Columbia where minors are empowered to give their own consent to obtain pregnancy tests, counseling, and referrals (Center for Population Options 1986, 3). In 12 of those States, the teens can consent for all of their own medical care, including pregnancy testing and abortion.

Some key Federal programs also carry similar explicit requirements. They provide a relatively small amount of the total SBC financial support nationally but have a profound influence all out of proportion to their number for two reasons.

First, receipt of funds from a source such as title X of the Public Health Service Act imposes requirements on the whole program. This provision is especially important in view of the efforts to pass new Federal SBC legislation that carries similar stipulations. For example, H.R. 3769 would pour millions of dollars into new SBC's and would require that they perform confidential abortion counseling and referrals.

Likewise, according to an authoritative book by two attorneys and a pediatrician on providing confidential health care to adolescents, a SBC is legally bound to provide teenagers with confidential abortion counseling and referral if it received any funds from titles XIX, medical assistance, and XX, aid to families with dependent children, of the Federal Social Security Act (Morrissey 1986, 63). The dollar amount of SBC funding from these two programs in 1986 was also rather small—about 2 percent of the total SBC funding (Lovick and Wesson 1986, 13). However, the income could increase in the future as more SBC's learn how to tap into these sources.

Federal programs also carry great influence for a second reason. Their operating policies determine national standards. Observed Asta Kenney or Alan Guttmacher Institute staff members, speaking at the annual SBC conference in October 1986, the title X program sets the standards for the entire "family planning industry," including, of course, SBC's. She noted that the title X guidelines require that recipient agencies provide services to minors without parental knowledge or consent (Kenney 1986).

Nondirective or objective counseling: SBC proponents assert that when the school clinics counsel pregnant girls about abortion, they employ the so-called "nondirective" methods used by Planned Parenthood and other members of the national family planning industry funded by title X. They claim to describe the two possible choices—abortion or birth—without promoting either one (1981, 23; U.S. Department of Health and Human Services 1981, 12, 13).

SBC's may even go so far as to state that they do not perform "abortion" counseling per se on the grounds that they present abortion merely as one "option." For example, the Center for Population Options' "School-Based Health Clinics: A Guide to Implementing Programs, avoids the word "abortion" by using the innocuous term "pregnancy counseling" which describes informing "pregnant patients" about "all of their legal options" (Hadley 1986, 89 and 34).

During policy debates, SBC advocates commonly make two misleading and inaccurate assertions about their counseling techniques. The first is that counseling can be performed in a neutral manner. The rhetoric of terms such as "nondirective" merely disguises the real agenda. "Counseling abortion would be pointless in the absence of an expectation that some women receiving such counseling will choose to have an abortion, " pointed out the Federal Department of Health and Human Services in its proposal on September 1, 1987, for new guidelines for counseling by title X grantees (U.S. Department of Health and Human Services 1987, 33211).

Offering counseling about abortion sends the clear message to the students that both the SBC and the school believe that abortion is a morally acceptable and medically safe practice. In other words, abortion counseling in an SBC represents endorsement by the policymakers of abortion as a possible "choice." So-called objective counseling by SBC's about abortion is impossible.

The clinic personnel's second deceptive claim is that so-called ethical considerations compel them to counsel pregnant teenage girls about abortion. "SBC practitioners,'"stated the SBC operating manual published in October 1986 by the Center for Population Options, "adhere to standards of medical ethics which state that pregnant patients are entitled to know all of their legal options, including of course, abortion" (Hadley 1986,34). Taking their cue from the family planning clinics funded by title X, the staff must provide that information and guidance, they assert, in order for the girls to give "informed consent" (Hayes 1987, 174).

Critics of this policy have pointed out two reasons why this line of argument falls apart under scrutiny. First, the proponents seriously misrepresent and subvert the traditions of the healing profession. Medical ethics places no burden on physicians and other health care professionals to support or perform abortion—in fact, just the opposite. By embracing abortion, the SBC advocates have forsaken the traditional "sanctity of life" ethic in western civilization, which has encouraged doctors and nurses to protect the health and welfare of all members of the human race, both born and unborn (Wardle and Wood 1982, 141-156; U.S. Congress. Senate 1982, 46).

Second, the events of the last 15 years have completely destroyed the credibility of the clinic proponents' alleged interest in promoting "informed consent." Their litigation in Federal and State courts has prevented enforcement of State and local laws requiring that a pregnant girl be given accurate and comprehensive information about the status of her pregnancy, the nature of the abortion procedure, and possible short- and long-term complications (Wardle and Wood 1982, 91-103; Horan, Grant, and Cunningham 1987, appendix 1.)

The evidence clearly reveals that the clinic proponents' assertions about being compelled by "medical ethics" to promote abortion is a thinly veiled disguise to justify their pro-abortion ideological and political agenda.

Despite these flaws in the rationalizations justifying counseling, a review of press reports of debates about SBCs discloses that school-clinic advocates have been quite successful in using their misleading rhetoric to defuse criticism. Most of the media and public attention has focused on abortion referrals, possibly because counseling a pregnant teenager may not appear to have as direct a cause-and-effect relationship with abortion as giving her directions to the nearest abortionist.

One final point that is extremely important in connection with the requirements of State and Federal law is the selective effect of the laws on SBC policies. Local elected officials and parents may not be aware that the laws would permit enforcement of parental consent regulations for some services in the school-clinic—such as athletic physicals—but not for others—such as abortion counseling.

In other words, the local authorities may erroneously believe that their parental consent policies control all of the clinic's activities when they actually control only part of them. The authoritative manual, "School-Based Health Clinics: A Guide for Implementing Programs," published by the Center for Population Options, explained that "laws in most States guarantee confidential family planning services to teenagers, but a different set of consent rules applies for general medical treatment" (Hadley 1986, 48). "At SBCs, staff members urge students to talk with their parents about sexual matters," states the manual, "but clinics respect the law insofar as informing parents directly about these matters" (Hadley 1986,32).

SBC proponents may refrain from pointing out when the law conflicts with policies approved by the school board, and one wonders how many parents are informed about the potential conflicts when their school board or city council is considering opening school clinics.

Counseling and referrals done when regulations do not prohibit them: A second category of clinics which provides onsite abortion counseling to pregnant teenage girls, pointed out by Asta Kenney at the SBC conference in Denver, is that which, in the absence of local or State laws or school regulations to the contrary, adopt the same policies as the title X-funded facilities. She explained that the staff assumes that the same rules of confidentiality that govern family planning clinics operated outside the school, also apply to SBCs within the schools (Kenney 1986).

This approach should not be surprising since much of the impetus for starting SBCs came from the family planning industry, including Planned Parenthood and other title X grantees. They are urging the SBC's to adopt the policies that they have employed for the last two decades in their facilities in the community.

According to Kenney, Federal programs which provide most of the government funding, such as the Federal maternal and child health [MCH] block grant—Title V of the Public Health Service Act—do not have specific stipulations either requiring or prohibiting parental involvement (Kenney 1986). According to a report compiled by the Center for Population Options during 1986, the MCH block grant provided 27 percent of the funding for SBC's (Lovick and Wesson 1986, 13).

Using indirect referrals to circumvent restrictions on counseling and direct referrals: When confronted with school regulations or parental prohibitions which prevent them from providing onsite pregnancy tests, abortion counseling, or direct referrals to abortionists, SBCs utilize two strategies to circumvent the restrictions to show pregnant teens how to obtain those forbidden services elsewhere.

One method is to employ the informal channels of communication within the school to inform the students where to go for pregnancy tests and abortion counseling. Speaking at a conference in San Diego in November 1986, Kathleen Arnold-Sheeran, a long-time nursing and administrative staff member of the St. Paul clinics and currently director of the National Association of School-Based Clinics, explained that the clinic staff in the St. Paul Program was careful to inform students that the clinic did not offer abortion counseling because of the terms of a special Federal grant from the Adolescent Family Life Program under title XX.

However, at the same time, the staff ensured that the girls knew the location of another facility nearby where they could obtain a free confidential pregnancy test and abortion referral. "We certainly talk to kids and let them know there are options available," she stated. "We just can't go into any details talking about abortions."

The result, pointed out the former SBC staffer, is that the pregnant girls who are considering abortion "don't come to us for their pregnancy tests." They went to the outside agency. This arrangement not only allowed the clinic to maintain a facade of not promoting abortion, but it also created the impression that the clinic was actually quite successful in convincing teens to give birth. Since the pregnant girls contemplating abortions avoided the SBC, almost all of the girls who received positive pregnancy tests at the clinic carried their babies to term. According to Arnold-Sheeran because "98 percent that come in for pregnancy tests continue their pregnancy" (quoted in Patton 1986).

In circumstances where the SBC performs abortion counseling but is prevented from referring girls directly to an abortion provider, the clinic staff uses a different plan. They direct the pregnant teens to an agency outside of the school, such as the local family planning or public health agency, which itself does not perform abortions. Then the outside agency, which is not covered by the school's or parents' restrictions, arranges to send the girls to another agency or facility, which does perform abortions.

This clever policy, while somewhat round-about, effectively accomplishes the objective. Moreover, it gives the SBC staff the semantic "out" they need because they can claim that they did not "refer" the girls to an abortion facility. Somehow the SBC staff believes that sending pregnant girls indirectly, rather than directly, to the abortionist, sufficiently changes the nature of the activity such that they are off the hook.

The director of public policy for the Center for Population Options, Jodie Levin-Epstein, explained how this duplicitous method operates in practice during her speech at the workshop at the Denver SBC meeting titled "Parents: Consent and Confidentiality" (Levin-Epstein 1986). "In practice, it is our understanding," she said, "that where a parent has not given consent for participation in a program, or in those instances where there is a checkoff for a particular program and the student for whatever reason isn't supposed to be served by that SBC program according to the parental consent form, the program refers for that service, or handles it in whatever way has been articulated by the advisory board."

Commenting on that policy at the same workshop, Cleve Holt, a nurse practitioner with the Orr High School Clinic in Chicago, said "We do not even mention abortion in the school-based clinic. If it does come up, we refer them out. We don't talk about it." (Holt, 1986.)

Steve Purser, health planning coordinator in charge of the Balboa High School clinic in San Francisco, gave a more extensive explanation of how this indirect abortion-referral policy operates during a workshop on March 6, 1986 at the annual meeting of the National Family Planning and Reproductive Health Association. His remarks are worth quoting at length.

Although his clinic is heavily supported by Federal title X money, which would normally require abortion referrals without parental knowledge or consent, he will not do that because "we don't want to usurp the parents' role." (Purser, 1986). "The last thing you want to do," emphasized Purser, "is to have a parent sign a consent form saying I want to exclude 'x' service, then provide that service to the child." Then he went on to reveal that the actual reason for ostensibly being so respectful of the parents' wishes was pure politics. If the clinic gave unauthorized services, "the school board would shut us down—literally," he stated emphatically.

Turning next to the issue of referrals, Purser asked himself the question of "What do we do if they, the students, come to us and the parent says 'I don't want my child to receive family planning'?" (Purser 1986). If that situation arises, or if there is no signed consent form at all, he explained that "they are referred to a clinic that is about a mile-and-a-half from us, which is another health department clinic that provides family planning services."

When the teenager is referred to the outside clinic, Purser stated, they "are no longer a student receiving health care at the high school; instead they become part of the general health system population."

Since the nearby city-operated health facility is not under the same restrictions as the school clinic, students receive medical treatment without parental knowledge or consent.

This point about the use of indirect abortion referrals should be emphasized because it is so important. If the SBC is prohibited from sending a pregnant girl directly to an abortionist, then clinic personnel can and will circumvent the parents' wishes simply by sending her to an agency or organization outside the school which itself does not perform abortions but which will refer the girl to someone which does perform abortions. Technically, of course, the SBC has not referred the girl directly for abortion.

Once a clinic opens in a school, this method for procuring abortions indirectly by utilizing referrals to outside agencies would be very difficult to identify and regulate. Moreover, if a controversy does develop over referrals, the clinic staff could raise new justifications for their actions, such as claiming that medical ethics or the students' "right to privacy" under Federal, State, or local laws. The best solution is not to open a school-based clinic in the first place.

In addition to referring pregnant girls for abortions both directly and indirectly, SBC's also promote abortion through their in-school education programs. The pilot programs in St. Paul and Baltimore, which have been widely emulated throughout the country, strongly emphasize the value of clinic personnel working closely with the school's health educators to develop the "reproductive health curriculum," and even to teach classes in order to establish rapport with the students (Ahartz 1986, 90; Zabin et al. 1986, 120, 125; Zabin et al. 1984, 425; Kapp 1986, 83).

This arrangement presents an extraordinary opportunity for the clinic staff to imbue the teens with pro-abortion concepts (usually described as presenting "all of the options") and to explain about the availability of pregnancy tests, of nearby abortion facilities, and of government funds to pay for abortions.

Dr. Douglas Kirby, the Center for Population Options' director of research, observed that the classroom presentations "not only serve an educational function, but a recruiting function as well" (emphasis added. Kirby 1985, 13). SBC expert Joy Dryfoos explained the "[c]linic staff often conduct sex education and family life [education] classes in the school, so they have ample opportunity to encourage the student in the classroom to attend the clinic" (Dryfoos 1985, 73).

Finally, Kathleen Arnold-Sheeran, an experienced clinic nurse and administrator for 13 years at the St. Paul clinic, stressed the importance of giving "lectures in the classes" at a workshop in San Diego in November 1986. "If you have a SBC without health education services, forget it," she emphasized. "It's no good" (quoted in Patton 1986).

Another abortion-related issue that to date has not played a role in debates over SBC's but could be very important in the future is worth mentioning here.

The potential for distributing the abortion pill to teenagers through school clinics was not lost on SBC proponents. In a story appearing in the Boston Globe on December 22, 1986, the chairman of Planned Parenthood Federation's Board of Directors, Dr. Allan Rosenfield, endorsed approval of RU 486 as a "major step forward for teenagers" (Franklin 1986, 1 and 14). He believed, reported the Globe, that if teenage girls who suspected they were pregnant "knew they could come to a clinic for a pill when their period is late, they would probably show up a lot earlier than they do now." Jonathan Brant, a Boston attorney specializing in health care issues, explained to the Globe that "[m]ost current restrictions, such as parental notification laws, would be unenforceable."

Clearly, clinics located inside of schools would be in an especially advantageous position to distribute abortion pills; therefore, one wonders whether clinics, in whatever current benign form that they make take at the moment, should be allowed to become entrenched so close to teenagers.

In order to minimize controversy, SBC advocates carefully "finesse" the abortion connection, to use Joy Dryfoos' apt description. SBC proponents employ several techniques to downplay this abortion linkage and hide their real agenda.

One approach for deflecting criticism is to deny direct involvement—which can be true—yet accomplish the same goal by referring indirectly. Another technique is to orchestrate the pro-SBC publicity and lobbying campaign under the guise of apparently disinterested and objective research.

The SBC advocates' third approach is to claim that the primary objective in promoting SBC's is not to further their own narrow pro-abortion agenda but to provide "comprehensive" medical services. However, SBC proponent Sharon Lovick has revealed how this is a smokescreen for their real objective—"doing something about adolescent pregnancy" (Lovick 1987). In fact, operating clinics inside schools offers Planned Parenthood and its allies an unparalleled opportunity to accomplish four long-sought-after goals: use the close proximity to the students and the school's authority to control the teenagers' lives, counter pro-life gains among the youth, add new sources of income, and diversify their range of medical services.

The right-to-lifers' second objection is to the misleading—and often completely erroneous—claims that SBC's reduce the number of teen pregnancies. A thorough review of their own statistics reveals how the hype does not square with the reality. Data from pilot clinics in St. Paul, Baltimore, and Chicago are simply inadequate to support any claims of success. SBC's may have been shown to reduce births, but that was achieved by increasing the number of abortions, not decreasing the number of pregnancies.

A spokesman for the leading organization promoting SBC's admitted in a speech last month that a preliminary study of clinics across the country revealed that they have had "no measurable impact" on teen pregnancy rates. Douglas Kirby, director of research for the Center for Population Options, candidly unveiled the results of a study by his organization in a March 2 workshop speech at the annual meeting of the National Family Planning and Reproductive Health Association (Kirby 1988). Although he prefaced his comments during the speech in the "Effectiveness of School-Based Clinics" with the caveat that they had not finalized the results, Kirby stated that "I am reasonably confident that what I am going to say will hold true." When reduction of teen pregnancies is one of the primary goals of title X, and there is no proof that SBC programs achieve that goal, SBC's should not be funded by Title X.

Finally, a third prolife critique of clinics is their policy of providing medical services, including abortion counseling and referrals, behind parents' backs. Individuals and groups who might not otherwise be strongly motivated to speak out about the abortion connection have joined anti-SBC coalitions because they grasped how clinics thoroughly undercut parental authority and seriously undermined the integrity of the family.

In addition to these three key criticisms, opponents have raised other major objections, financial and moral, to clinics. Their financial considerations include questions about the high cost/low cost-effectiveness of the clinics; the inevitable requirement for Government funding; and the need for extensive medical liability insurance coverage. In addition, many parents and other concerned citizens are justifiably worried that the clinics will overburden school systems which are barely able to achieve their fundamental educational mission now. And finally, critics have pointed out the racist implications of targeting the clinics almost exclusively in inner-city minority neighborhoods.

Another objectionable provision of H.R. 3769 is the so-called contraceptive development initiative, which authorizes a new source of funding for so-called contraceptive development and research. This section would encourage Federal support for development of new abortion-causing drugs and devices, such as the abortion pill RU 486, which proponents have consistently mislabeled as "contraceptives." For example, in late 1986, RU 486 supporters abandoned their promotion of using the drug to cause an early abortion, and they have concentrated on perfecting techniques for using the abortion pill after a woman misses her menstrual period and knows she is pregnant. (Murphy 1986, 64; Kolata 1988, Al; Steinbrook 1988.)

The obvious purpose of this proposed amendment to title X in H.R. 3769 is to provide the funding that RU 486 promoters have been unable to secure from pharmaceutical companies in the United States, which have refused either to test or market the pill for two reasons. (Kolata 1988, A1; Family Practice News 1987; Gapen 1987.) The companies' executives recognize how vulnerable they would be to liability lawsuits from selling such a dangerous drug. They also recognize that any drug company which approaches the FDA for permission to market an abortion pill will become the target of a massive and long-term boycott by prolife organizations and churches.

During the past 6 years, a French drug manufacturer, Rousell-Uclaf, assisted by researchers in the United States and at least 10 other countries, has employed RU 486 in experiments on thousands of women to induce abortion by blocking the action of an essential hormone, progesterone (Kolata 1988). The antiprogesterone drug, whose name is derived from the company's initials [RU], disturbs the delicate hormonal balance of pregnancy, and is much more complex and subtle than surgical abortion, which involves cutting up and scraping the baby out of the womb.

Depending on when RU 486 takes effect, the result is either to prevent implantation of the growing human in the uterus or to dislodge the baby from the wall of the uterus after implantation (Baulieu 1985; Spitx and Bardin 1985.) Proponents have offered an exotic variety of names for the action of the pill, but what matters is not the misleading labels but the fact that fertilization has occurred. Thus, the action of RU 486 is not of an contraceptive but of an abortifacient. Whether the drug takes effect before or after implantation, the baby dies when the lining of the uterus starts to slough off, and the woman starts bleeding.

RU 486 and similar antiprogesterone drugs which could be developed in the future, kill the baby after fertilization and are totally distinct from true contraceptives which prevent fertilization.

While RU 486 may not meet all of the criteria of pro-abortion supporters for the ideal method of stopping unwanted births, it certainly goes a long way. When proponents of RU 486 claim that the drug could replace 80 percent of surgical abortions, they are clearly assuming that the most women who currently abort their babies would never face the problem of a crisis pregnancy if they routinely took a monthly abortion pill. "In all cultures and throughout history," explained Dr. Allan Rosenfield, Planned Parenthood's chairman of the board, to a Washington Post reporter, "women have looked for a drug that will bring on the period [i.e., cause abortion]" (Rosenfield 1986, C1).

Proponents of RU 486, such as the leading researcher Dr. E.E. Baulieu from France, and Dr. C. Wayne Bardin from the Population Council in the United States, recognize that they face an uphill battle to win approval from the FDA to market the drug because of safety considerations and political opposition from the right-to-life movement. (Rosenfield 1986, CBS Morning News 1986.) In order to swing public sentiment in favor of making the drug available in the United States and neutralize prolife resistance, they have consistently misled both the public and press about RU 486's abortifacient properties.

Bardin, Baulieu and other supporters anticipate that millions of women would opt to replace their current method of birth control with a monthly dose of RU 486. (Baulieu 1985, Spitz and Bardin 1985.) The drug could be taken at home with a doctor's prescription ostensibly to "cause menstruation"—induce bleeding in the uterus. The only noticeable external difference might be a heavier menstrual flow. RU 486, in their view, serves as a simpler, once-a-month substitute for daily contraceptives, and is more fool-proof in preventing births. Moreover, the researchers also expect that the abortion pill could be taken as a "morning-after pill" after what they describe as "unprotected intercourse."

Media interest in RU 486 came in two distinct waves in 1986. In the spring, the New Republic magazine ran an influential article by Tony Kaye titled "Are You For RU-486." (Kaye 1986, 14.) Like most stories in early 1986, Kaye failed to clearly explain that RU 486 was not a contraceptive but an abortifacient. The second wave came in December, sparked by a special session at a conference sponsored by the strongly pro-abortion Catholics for a Free Choice and an article and editorial in the influential New England Journal of Medicine. (Couzinet, et al. 1986, 1565; Hansen 1986, 7.) Interestingly, by December most accounts correctly described RU 486's abortifacient properties.

To most people, conception is synonymous with fertilization, the unique moment of union of sperm and egg. (For example, Stedman's Medical Dictionary [1982, 308] and Blakiston's Gould Medical Dictionary [1984, 305].) In this sense, a contraceptive would prevent fertilization. (National Right to Life takes no position on contraception.)

However, the proponents of RU 486 are using contraceptive as it was redefined in the late 1960's by the American College of Obstetricians and Gynecologists [ACOG] (Hughes, 299.) ACOG threw out the traditional meaning and made conception synonymous with implantation, the time several days after fertilization when the developing human embeds itself in the lining of the mother's uterus.

By ACOG's redefinition, RU 486 does act as a contraceptive when it acts to prevent implantation. Even by ACOG's elastic definition, RU 486 remains an abortifacient when it is expected to be most widely used because it causes the uterus to slough off the developing human after implantation.

The researchers themselves may inadvertently have helped establish the reputation of RU 486 as an abortifacient by selecting an abortion experiment to publicize their product in December 1986. Much of the press attention surrounding RU 486 centered around the lead article in the December 18th issue of prestigious New England Journal of Medicine which described using RU 486 to induce abortions in women who were 4 to 5 weeks pregnant. (Couzinet 1986, 1565.)

The beauty of the drug, from the view of the abortion crowd such as Planned Parenthood and its media sympathizers is that the woman need never know that she is pregnant. The abortion pill is so appealing to them because it helps a woman rationalize her way out of the guilt associated with killing her unborn baby. As Dr. Baulieu pointed out, RU 486 offers a woman a "much less traumatic form of abortion, both mentally and physically." (Bardin 1985.) RU 486 represents what women have always wanted, say Planned Parenthood, the National Abortion Rights Action League and others: a method of no-guilt, no-planning and no-responsibility birth control.

How ironic that these are the same supporters of unrestricted abortion who have constantly defended *Roe* v. *Wade* in the past on the ground that women do not take the decision to abort frivolously. They claim that women grow emotionally when they decide to abort rather than nurture; that abortion must remain available as a moral choice. However, if RU 486 has widespread use, choice is out the window, and self-deception is in. Just how absurd this can become is demonstrated by the fact the proponents of choice are consciously trying to mislead the public into believing that RU 486 is a contraceptive rather than an abortifacient.

Their assessment of the potential impact of the drug emphasizes the short-term relief that women may experience and ignores the potential for long-term guilt associated with taking the abortion pill month after month and year after year. Women may be able to rationalize themselves out of the situation, but perhaps not. In this case the woman herself could be performing the abortion each month by taking the pill.

In searching for opposing viewpoints about the new drug, the press usually failed to note the growing criticism from two groups within the pro-abortion ranks questioning the safety and morality of the drug. First, as researchers conduct more clinical trials during the next few years on RU 486, we are likely to hear more from feminists and health care professionals voicing their concerns about how the drug affects women's health. Despite a strong pro-abortion bias, these groups maintain a healthy skepticism toward any new birth control method in view of the past callousness demonstrated toward women by drug companies and organizations such as the Rockefeller Foundation and the Population Council, which are actively promoting RU 486 (Boston Women's Health Collective 1980, viii–ix; Network News, 1984, 5; Corea 1985, 3; Ehrenreich et al. 1979, 31.)

Much like the ill-fated Dalkon Shield, the abortion pill, RU 486, is being hyped as a safe method of birth control, and the print and electronic media has repeated claims by the abortion pill's promoters without scrutinizing them adequately. Of course, this powerful abortion pill is lethal for unborn babies, but it also has extremely hazardous short- and long-term side effects for pregnant women who take it. Tests during the past 6 years have revealed several important immediate side effects, including severe nausea, mild uterine pain, vomiting, weakness, and fatigue (Spitz and Bardin 1985, 260-262; Baulieu 1985, 1 and 19.) Despite reports of no evidence of damage to the hormonal system from taking the drug, the long-term effects of repeated use of RU 486 will not be known for years. Ironically, in order to promote RU 486, its supporters have described how unsafe current surgical abortion techniques are.

Every pregnant woman who takes RU 486 has a miscarriage and heavy bleeding. Researchers reported in the British medical journal Lancet that half of the women who took RU 486 bled 12 days or more, and some bled for 6 weeks (Rodger and Baird 1987, 1416.) Most of them had twice the amount of bleeding of a normal menstrual period, and some had six times as much.

Moreover, if a woman with an ectopic pregnancy—in the fallopian tube—takes RU 486, the bleeding will give her a false impression that she is no longer pregnant; however, the eventual rupture of her fallopian tube would endanger her life (Herrmann 1985, 187.)

Many prospective patients would probably not be thrilled to learn that drug is not very effective in what it is designed to do—cause abortions—and the researchers acknowledge that they do not know why (Baulieu 1985, 16-17.) The rate of complete abortion in various experiments has varied widely, usually in the range of 70 to 90 percent, which the researchers regard as unsatisfactory. Moreover, they are still searching for the optimum dosage and timing of the RU 486 pills—contraception supplement 1987.

Moreover, when the abortion pill does not produce a complete abortion—between 5 and 15 percent of the time—the woman must have immediate surgery to stop the bleeding and repair the damage (Rodger and Baird 1987, 1417-1418.) Also since the drug has been tested for less than 5 years, the first generation of RU 486 users will be guinea pigs to determine the pill's long-term effects on women's health and fertility.

To date, no conclusive evidence exists that RU 486 is anything more than a killer drug. Advocates of RU 486 have exaggerated the fragmentary results from a mere handful of tests about possible therapeutic uses of the drug.

The second set of pro-abortionists with some reservations about RU 486 are commentators usually sympathetic to the abortion movement who profess to be uneasy with promiscuous and routine use of abortion. They see disastrous social and moral consequences if women turn exclusively to the abortion pill as the sole method of stopping births.

For example, columnist Ellen Goodman explained that "only a hardcore few—abortion advocates—are comfortable with the notion of using abortion as birth control" (Goodman 1986, A23.) Moreover, she wrote "RU 486 would surely increase that use." In addition, "[a]bortion ought not to be traumatic, but should be serious," she wrote. If abortion became available through a pill, the "moral questions would be easy, perhaps too easy to avoid," she concluded.

The media's projection that the American public would welcome an abortion pill is based on an inaccurate and one-sided reading of public opinion polls about abortion. The majority of Americans are opposed to legal abortion except for a very narrow set of hard cases, such as rape, incest, and endangerment of the life of the mother. Most Americans definitely do not support the current situation, where no more than 1 percent of abortions are done for these so-called hard-case circumstances. Marketing RU 486 in the United States would heighten—not decrease—the public's uneasiness about abortion because the pill further trivializes the decision to take innocent human life.

In view of strong opposition from the right-to-life movement and publicity about these ethical and safety drawbacks being raised even in some pro-abortion quarters, proponents of RU 486 such as Dr. Baulieu remain cautious about projecting when RU 486 might be marketed in the United States as a pill to cause very early abortions. However, the "major barrier to introduction of any birth-planning method," Dr. Bardin stated on CBS Morning News, remains "how much money is it going to make?" (CBS Morning News 1986.) Drug companies are unwilling to shoulder the potential liability costs of costly litigation if someone is hurt by the drug.

National Right to Life's opposition to RU 486 arises out of a concern to protect both the life of the unborn child and the life and health of her mother. American women aren't looking for a "chemical Dalkon Shield." Neither are we.

Mr. WAXMAN. Thank you very much for your testimony.

Mr. GLASNOW. Can I correct this? I think I made a mistake. RU 486 is an abortion pill, and it is a month-after pill. I think I might have made a mistatement as I was reading.

Thank you, sir.

Mr. WAXMAN. The record will reflect that correction on your part.

Professor Weed and Mr. Schwartz, both of you suggest that family planning services lead to an increase in teenage pregnancy. Yet neither of you take into account the phenomenal increase in sexual activity over the past 20 years.

Evidence shows there was a two-thirds increase in sexual activity in the 1970's. Over the same time period there was a 10-percent increase in teenage pregnancy. Doesn't that suggest that contraception has been working.

Mr. SCHWARTZ. There was not a 10-percent increase in teenage pregnancy during that period. It was about 150 percent during that period. But you will also note that——

Mr. WAXMAN. Do you have a study for the record that would indicate that figure?

Mr. SCHWARTZ. Ten percentage points or in the number of teenagers who became pregnant?

Mr. WAXMAN. You made the statement there was 150 percent——

Mr. SCHWARTZ. The number of teenagers, unmarried teenagers, pregnant in 1970 was about 300,000. The number of teenagers who were unmarried and pregnant in 1980 was over 700,000. That is approximately 150 percent increase in the number of out of wedlock teen pregnancies.

Mr. WAXMAN. I would like you to submit that. I agree that the number of teenage births out of wedlock has gone up. But it seems that the key point is not the number of teenage births which has been going down even before family planning services and abortion were widely available, but the striking decrease in the number of teenagers getting married.

Mr. **Schwartz**. Teenagers are not at all getting married anymore, not merely as they were before. Fewer teenagers are married and as a consequence of that, a greater proportion of the births to teenagers are out of wedlock births.

In 1970 about one-third of the births were nonmarital. By 1980 it was about half, and currently a majority of births to teenagers are out of wedlock. That is only a small proportion of all pregnancies among teenagers and among all teens unmarried.

Two-thirds of the pregnancies to unmarried teenagers end in abortion.

Mr. **Waxman**. How is the family planning program responsible for the decisions of teenagers not to get married?

Mr. **Schwartz**. I will be happy to explain that, sir. Not to get married but to become sexually active.

Mr. **Waxman**. That is not my question.

Mr. **Schwartz**. It is responsible for the decision for teenagers to become sexually active, and to expose themselves to the risk.

Mr. **Waxman**. That pregnancy rate hasn't gone up?

Mr. **Schwartz**. It has gone up 150 percent in 10 years.

Mr. **Waxman**. Unmarried pregnancy rate has gone up. The marriage rate has gone down?

Mr. **Schwartz**. That is right.

Mr. **Waxman**. If there is more sexual activity and more pregnancy and you find that those getting pregnant are not married, then it is unmarried women becoming pregnant.

Mr. **Schwartz**. That is the social problem.

Mr. **Waxman**. I am not denying the problem. I am not denying it is a matter of great concern. It is sweeping to say that family planning program is responsible for all the unmarried pregnancy when we can't show why the family planning program is not leading people to get married.

Mr. **Schwartz**. No. The reason why premarital pregnancy is increasing is not because people are getting married. It is because more unmarried teenagers are beginning to become sexually active. That is something the family planning clinic program contributes to in three ways.

First of all——

Mr. **Waxman**. Excuse me.

Mr. **Schwartz**. I have to answer the question you were asking me.

Mr. **Waxman**. I want you to understand what I wanted answered. Data show that while there was a two-thirds increase in teenage sexual activity in the 1970's, at the same time period, there was 10 percent increase in teenage pregnancy.

Mr. **Schwartz**. That is incorrect, sir. The increase in premarital teenage pregnancy was 150 percent, approximately.

Mr. **Waxman**. Married and unmarried?

Mr. **Schwartz**. Married and unmarried. I don't know what that number is, but I doubt that it was——

Mr. **Waxman**. I have a 10-percent increase.

Mr. **Schwartz**. Married teenagers becoming pregnant and having babies is not the kind of problem title X is——

Mr. **Waxman**. I must beg to differ. The title X, family planning program, is not just for unmarried people. It is for married people and people who want to control when and if they are going to have children.

Mr. **Schwartz**. Married women having babies is not a social problem. The unmarried women problem is.

Mr. **Waxman**. It is a problem that they might want to get contraceptive information and——

Mr. **Schwartz**. I propose only unmarried minors be disqualified from family planning services under this program.

Mr. **Glasnow**. Mr. Chairman——

Mr. **Waxman**. Excuse me. I want to ask questions. I want to ask you a question, Ms. Gasper, because I was intrigued by the analogy you made between giving teenagers advice as to where to buy bullets for a gun—which is illegal under most laws, and some people claim, even under the constitutional right to bear arms—and giving teenagers information about abortion services, which are legal and constitutional.

What about grownups? Why shouldn't the grownup be told that? While I don't like people to have guns, they can go buy a gun. You may not like the idea they may choose to have an abortion, but a doctor should be able to tell his patients abortion is an option.

Ms. **Gasper**. That is very fine as long as tax dollars are not supporting that advocacy activity. I would no more support tax dollars supporting the National Rifle Association to go and argue for the right to bear arms than I would for Planned Parenthood to get title X funds to argue for the right to have an abortion.

Mr. **Waxman**. Well, you talk about tax dollars, but if tax dollars are going for a clinic—and maybe you don't think family planning under any circumstances ought to be there, but the Congress has decided we want tax dollars to go to fund clinics where women can come in and get information about their health, maternal-child health, and contraception—it seems to me that a woman ought to have the right to get the information about abortion if she comes into that clinic.

A grown-up woman ought to have the right to get the information available to protect her health and maybe even to save a life.

Ms. **Gasper**. Congress, in its wisdom, enacted statutes. And normally when you do that, you say you want the dollars, the tax dollars to be spent for a specific purpose. Under title X there was a very explicit prohibition that the title X program is not to promote abortions or advocate in favor of abortion.

There is a long statutory history. There is a long legislative history, and numerous general counsel opinions that say that abortion is outside of the title X program. No Federal funds should be used in the title X program to promote abortion.

Therefore, if somebody, back to our analogy, wants to discuss an abortion, they may do so. They have to do it outside of title X.

Mr. **Waxman**. Is it promoting abortion to discuss the fact that there is a procedure called an abortion which may be an option available to a woman under certain circumstances.

Ms. Gasper. I would say, given the abuse found by the general——

Mr. Waxman. I am not asking about abuse. Excuse me.

I am asking about the very fact of telling a woman who has been raped, and who is pregnant, that abortion is an option to her if she chooses it. Giving the child up for adoption is another option; carrying the pregnancy to term is another.

Without directing or promoting any one of those options, do you think it is promoting abortion simply to say that abortion is available as an option?

Ms. Gasper. 86.4 percent of pregnant women are referred for an abortion. I think that does promote abortion, and that is outside the statute.

Mr. Waxman. So, you are saying you believe that there are a lot of referrals for abortions or a lot of abortions taking place and, therefore, even mentioning it as an option to a person should be prohibited?

Mr. Glasnow. I think the program should be administered according to the law and regulations. There have been abuses within the program. The program should be administered in strict compliance with the law.

Mr. Waxman. Therefore, because there has been abuse over there, a woman over there, who has been raped, should not be told abortion is an option? A woman who has a possibly fatal disease if she carries the pregnancy through full term shouldn't be told?

I am not even asking you that question, because that is exactly the point we have gone over. If there are abuses here, you are saying that we should deprive people of information over there. That is not—it may be your opinion. It is not my opinion of what the Congress intended. And it is not the opinion of Congressman Dingell who authorized the provision saying, that we in Congress don't want abortion to be funded by the family planning——

Ms. Gasper. I do not think if Mr. Dingell had not made his floor statement that title X would have been enacted.

Mr. Waxman. I don't disagree with that.

I wasn't here at the time. But Mr. Dingell was and if title X was enacted——

Ms. Gasper. He said these words and the program was enacted.

Mr. Waxman. He submitted a letter and I have the letter which we have now made part of the record.

He makes clear:

> In addition to relying on an incomplete legislative history, the department has also quoted passages from my Floor statement out of actual and historical context, to imply things that were not said, and which may not be reasonably inferred. My statement was made in opposition to the use of Federal funds to support or encourage abortion as a form of birth control.
>
> The statement did not suggest either expressly or implicitly that family planning clinics should be prohibited from counseling pregnant women, or any party, or referring them to appropriate facilities, or of recordkeeping distinct, facility requirements, constraints on political activity or the taking of a negative oath by clinics. Proposed regulations erroneously suggest that statement somehow supported these goals.

Those are the statements from Congressman Dingell, who you are citing as the source for the regulations that are being proposed.

Ms. **Gasper**. The intent of Congress when title X was enacted, was not to promote, advocate, or encourage abortion. And I think that when you have abuses in a program, when there are problems, then it is very prudent for program managers to take the steps necessary to ensure strick compliance.

Mr. **Waxman**. Thank you very much.

Mr. Nielson.

Mr. **Nielson**. Thank you, Mr. Chairman.

The doctor suggested in his testimony that family planning clinics encourage teens to involve their parents in decisions about using contraceptions. Do any of you agree or disagree with that?

Ms. **Gasper**. I think Dr. Fox and the region he is from has primarily a State-administered family planning program. He is speaking from experience in Alabama.

I have no qualms with that. When you look at the program, however, nationally, there is a great deal of variety and I don't think his comments hold true across the board.

Mr. **Schwartz**. I would say it is rather difficult to involve parents in the whole process when they are forbidden to know that their children are involved in it.

I mean it is impossible to have parents totally involved unless you have parental notification first. You can't expect people to become involved in what they don't know about.

Mr. **Nielson**. If there is proposed funding of title X through the States directly, do you agree with that, Dr. Glasow? Do you agree?

Mr. **Glasnow**. I am not qualified to deal with that issue. We would be happy to provide a written answer.

Mr. **Nielson**. Dr. Weed, do you have anything to add to that?

Mr. **Weed**. I can speak to the question in terms of my State. We have a State task force on teen pregnancy, and we are well qualified to administer our own program and would like to do so.

At the current time, we are prohibited from doing that. We have a parental consent and notification requirement.

Mr. **Nielson**. Do you know any other States making headway besides Utah?

Mr. **Weed**. Not that they are making inroads on. At the State level, no.

Mr. **Nielson**. Would you say the country is losing the battle on teenage pregnancy?

Mr. **Weed**. Yes, we are losing it. The title X program in spite of all the efforts and funding, has shown very little impact.

Mr. **Nielson**. Mr. Schwartz said teen pregnancy increased by 150 percent. Do you agree?

Mr. **Weed**. Unwed teens, that is correct.

Mr. **Nielson**. The point the chairman was making is the total sexual activity may stay the same. If you have a smaller percentage who marry, that would increase the unwedded. He was trying to raise that with you.

Could you refute that?

Mr. **Schwartz**. I will try to clarify it, sir.

I think the number of pregnancies and number of births to married women who are under the age of 20 is relatively irrelevant to the success or failure of title X because most of those births if not all, are intended births.

If the number of young women under the age of 20 who marry is reduced, than naturally the number of babies they intend to have is reduced. The social problem which we know under the label "teen pregnancy" really is the problem of unmarried teenagers becoming pregnant.

The total number of unmarried teenagers who became pregnant was 2½ times as high in 1980 as in 1970. And very little of this was due to population increase because the teen population peaked in 1976.

Mr. **Nielson**. How much would have been reduced if the marriage rate stayed the same?

Mr. **Schwartz**. No difference at all that I can see, sir, if the marriage rate stayed the same. The only thing the marriage rate does is change the relative balance between marital and out-of-wedlock births among teenagers.

Mr. **Nielson**. Dr. Weed, you mentioned on page 4 that demonstration programs indicate it's possible to aid in the AIDS crisis. Can you give me an example of that. The sexual involvement and, therefore, help cut down the amount of AIDS.

Mr. **Weed**. Programs come to mind. We are evaluating two, one of which has demonstrated a reduction.

We don't find that kind of reduction in a title X kind of program.

Another illustration, from a project up in Chicago: 15 school districts are involved, and we find huge shifts in kids attitudes and values, and beliefs about premarital sexual activity, and we are suspecting that we are going to see that transfer into behavior and reduction of pregnancy.

Mr. **Nielson**. Your statement on page 5, seeing about the parental involvement and factors of improved situations were as ignoring and dismissing and minimizing the roles of the parents caused problems.

Mr. **Weed**. There is a project reported funded through title XX and additional support given by the Ford Foundation. They looked at the repeat pregnancy rate for girls who had a child out of wedlock.

They were trying to reduce the repeat pregnancy rate in a situation where the parents are directly and heavily involved. The repeat pregnancy rate was 1 out of 15. The control group under the usual kind of approach, one out of four. So the difference was about 300 percent by involving parents in a significant and meaningful way.

Mr. **Nielson**. I am going to ask you and Dr. Glasow the same question.

You didn't have a chance to finish your statement. Three minutes is not enough time. You didn't get to page 6, but you say something about our recommendations would be to reassign one third portion of the title X funds currently used for teenage clients and establish a new and different program in line with the criteria listed above that has promise for solving the problem.

A second recommendation would be to evaluate more systematically and more objectively, from independent sources, not only this new trust but the existing title X programs that have operated on untested assumptions.

What would you recommend we do with the present legislation proposed by, number one, the administration and, two, by Waxman and Madigan. What would you do about those two pieces of legislation?

We have not seen the details of the administration's but what would your recommendations be?

Mr. Weed. Whatever title X may do for other segments of the population, what it doesn't do is contribute to the net solution of teenage pregnancy. If we knew what we know now, we would never assume title X would be a solution to the pregnancy problem.

We can't go another 15 years assuming that we have a solution. Therefore, with that experience now behind us, we ought to be able to move ahead in a different direction, building in those criteria I have suggested and make a difference in reducing teenage pregnancy rights.

Mr. Nielson. Let me ask a blunt question. Would you recommend abolishing title X entirely?

Mr. Weed. No. I think part of it makes a contribution.

We can't take it as a lump sum and ignore those parts that are failing so drastically.

Mr. Nielson. Mr. Schwartz, you certainly indicated if you cut the funding you will also cut the teenage pregnancy. The logical conclusion is if you eliminate the funding you are closer to eliminating teenage pregnancy.

Mr. Schwartz. That has to be weighed against other possible objectives. The subject of my scholarly investigation has been the effect of title X on teenage pregnancy. It is disastrous.

Disqualifying unmarried minors from eligibility for contraceptives through title X would significantly improve the situation of out-of-wedlock pregnancy. Reducing the funding by one third to note the fact that family planning clinics would be losing a large part of their clientele would probably also be a healthy thing to do.

Mr. Nielson. Dr. Glasow, Dr. Fox testified that the availability of family planning services actually reduced incidents of both pregnancy and abortion among teenagers. Would you comment on this statement?

Mr. Glasnow. Our basic problem with the title X program as currently being administered is that it promotes abortion.

Mr. Nielson. You are suggesting the opposite, it promotes abortion and increases teenage pregnancy, or——

Mr. Glasnow. We are not making a statement about the increase in pregnancies. We are focusing on the abortion issue and our concern is the fact that it is allowing organizations to get Federal funds to promote abortion, contrary to the original intent of the legislation.

Mr. Nielson. Let me ask you this question: if you had the power, would you abolish title X entirely.

Mr. Glasnow. There are many systematic problems with title X as currently set up. The Chairman's proposed legislation would make that worse. We oppose the proposals that I have outlined in my testimony.

Mr. Nielson. You oppose the school based clinics primarily and you also oppose the use of RU 486.

Mr. GLASNOW. Right, and similar abortion causing drugs and devices. As far as title X is concerned, the larger issues are in the courts, and in the best possible situation.

If title X is returned to its original family planning intent where it doesn't promote abortion, we would be hands-off. We are interested in the abortion issue.

Mr. NIELSON. Two more questions.

Mrs. Gasper, you were formerly Deputy Assistant Secretary for Population Affairs. I understand there is a curriculum you almost provided to a New Hampshire clinic which you have concerns about and which talks about the evaluation and review of title X projects.

Can you speculate how this might be consistent or inconsistent with title X?

Ms. GASPER. The Dover, NH, clinic or curriculum is inconsistent with title X in many aspects.

Mr. WAXMAN. That is what he said.

Mr. NIELSON. Why do they receive title X funds in that case?

Ms. GASPER. That is a good question. It is an example of the problems with the program where groups are receiving funds to do things not consistent with the statue.

Mr. NIELSON. How about secondary education programs. Are they consistent with title X objectives?

Ms. GASPER. Depends on the program. Title X does fund secondary education.

Mr. NIELSON. Were you dismissed from your job because you were refusing to go fund some of the secondary education programs?

Ms. GASPER. I was fired because I refused to fund two training programs, and I did so because to fund them would have been unlawful and inappropriate as well as contrary to my moral convictions. The primary thing was it was unlawful, and I was not even permitted to administer the departments rules to see for instance, where the programs were within compliance. I was told I could not look at the grants in order to fund them.

Mr. NIELSON. Did you speak or obtain any help when you were fired from the government employees union or any groups of that nature?

The reason I ask the question is because I serve on another committee with some 33 people, 33 people lost their jobs because they went from a specific categorical program to a block grant program. There was no need for the administers.

As I understand the administrations program, they are going to need future administers in the Federal level. We will have to then reduce those jobs and that was in the field of education.

There was a furor over it that lasted 3 years. You didn't seek that kind of determination——

Ms. GASPER. Sir, there is a fellow named Ernie Fitzgerald who was responsible for the whistle blower legislation that protected Federal bureaucrats from inappropriate firings. Fitzgerald——

Mr. NIELSON. You didn't seek remedy.

Ms. GASPER. I was a political appointee and served totally at the discretion of the Secretary of the Department of Health and Human Services.

Therefore, I did seek whistle blower protection, and I could not get whistle blower protection because I was a political appointee.

Mr. **Nielson**. That goes beyond the scope of this hearing. I apologize.

It was intriguing to me that some employees seem to be able to hang on to this when the discretion of their boss, they no longer need it or they are not going along with the regulations as they see them, but you apparently were not.

Ms. **Gasper**. I was not eligible because I was——

Mr. **Nielson**. Appreciate that clarification.

Mr. **Waxman**. You were fired because you were given direct orders by your supervisors to do something, which you didn't want to do and didn't do. You were, therefore, fired for insubordination.

Ms. **Gasper**. I was fired because I refused to fund, to use taxpayer dollars to fund grantees whose activities would have been unlawful and inappropriate.

Mr. **Waxman**. That was your view, but your superiors had a different view and ordered you to sign some papers.

You felt it was unlawful. They felt it was lawful. They told you to sign the papers. You said you wouldn't.

Ms. **Gasper**. On the grants expired at the end of June. I was ordered four or five times to fund the grants.

I had requested permission to review the grants to take appropriate administrative action if needed. I was denied permission to review.

I was ordered to fund. I told my supervisors the reasons why I felt it was unlawful to fund and explained to them if they wanted the grants funded they could sign, the Secretary could sign, the Assistant Secretary could sign, or two members of my staff could sign. If I may finish the story leading up to my firing.

Mr. **Waxman**. Do it very briefly. Basically, what you are saying is you didn't think you should do what they wanted you to do?

Ms. **Gasper**. I felt it was unlawful.

Mr. **Waxman**. They fired you.

Ms. **Gasper**. After the grants expired. I sought general counsel advice on whether it was appropriate to fund or not.

I was told by general counsel of the United States Department of Health and Human Services that it was inappropriate to fund.

Mr. **Waxman**. OK.

Ms. **Gasper**. I did not fund.

Mr. **Waxman**. Mr. Glasnow, I am sorry, I am not sure whether it was Mr. Schwartz or Dr. Weed who said he didn't think title X ought to be providing contraceptives to teenagers that were unmarried.

Do you agree with that, that title X should not be permitted to provide contraceptives for teenagers that are not married?

Mr. **Glasnow**. My organization takes no position on contraceptives at all.

Mr. **Waxman**. That is not your issue. OK.

I wanted to clarify a point on the legislation, H.R. 3769, about school-based clinics and abortion inducing drugs. Current law neither requires nor prohibits school-based clinics. Current law doesn't say one thing or another about them. The department has said that it doesn't intend to start these programs.

Our bill does not require or prohibit such clinics or such drugs. We just don't do anything other than what current law now provides.

I want that to be clear to you. You, I suppose would like to have it prohibited.

My legislation doesn't require them to do it and they seem to be unwilling and have no intention to do that sort of thing. They are not inclined to do it. We don't tell them to do it.

We don't say they shouldn't do it. We don't change current law in that respect. Is that your understanding?

Mr. Glasnow. The legislation you proposed would allow the funding to go forward if, for instance, the department made the decision to do it. Is that correct?

Mr. Waxman. Current law allows them to use funding for contraceptive research purposes, if they chose to—for research on something that is not contraceptive as you see it. If we give them more money to do contraceptive research and they decide to do research on this RU 486, they could do it. We don't direct them to do that research, however.

Mr. Glasnow. This would be a new initiative that would encourage the department to move into these areas. In particular, it is important to keep in mind the companion bill on the Senate side which is promoting not only the research, but the marketing.

Mr. Waxman. I want you to understand and I am not sure what the Senate bill provides, our bill doesn't provide anything about marketing, promoting this drug or this kind of research.

It is clearly a statement that there ought to be more research on contraceptives and leaves current law in place to decide what research the Department wants to do.

Mr. Schwartz you said a statement that puzzled me. Do you believe that current law forbids parents to know that their teenage children are in a clinic?

Mr. Schwartz. It forbids clinics personally from notifying the parents if the child does not first initiate that contact.

Mr. Waxman. That is different than your statement awhile ago that parents are forbidden from knowing.

Mr. Schwartz. If their child doesn't want them to know.

Mr. Waxman. I authorized a provision in the title X law that says that the clinics should encourage family involvement and should encourage teenagers to have their parents brought into these discussions. But the provision doesn't mandate involvement because in every circumstance in my view, it shouldn't be mandated.

Ms. Gasper. Programs funded by title X discourage family involvement and say basically that the parents should not be involved.

Mr. Waxman. I haven't seen that. Submit that to us and if it is inconsistent of the idea of encouraging family participation, I certainly wouldn't——

Mr. Schwartz. Since your comment was directed to me, we simply have a disagreement of opinion. I can't imagine how families can be involved if there are circumstances under which their children would be enrolled in those programs and they wouldn't be allowed to know about it. There are such circumstances.

Mr. **Waxman**. You can't imagine how parents can be involved if the teenage person has the right to not bring them in?

Mr. **Schwartz**. No. I can't imagine how parents can be involved if their child does not bring them in. You know——

Mr. **Waxman**. I can—I don't have any disagreement with that.

Mr. **Schwartz**. The thrust of the language you added to the program in 1981 or—whenever it was, really had no effect.

It still left the ability of parents to know when the government was giving drugs to the children for whom they are legally responsible, up in the air.

Mr. **Waxman**. The difference we have is whether the teenager should be encouraged by the clinic to have the family involved in the discussions and decisions or whether the teenager should be forced to include the family. Clinics are supposed to encourage involvement.

The question is whether you mandate it under every circumstance and you are correct that we do not mandate it. After discussing it with the teenager, for all sorts of different reasons, it may not be best to involve the parents. Parents themselves may be the problem.

There may be sexual abuse of the child. There may have been an absolute disregard by the parents. Under those circumstances it is not required by law that the parents be notified and brought in.

Mr. **Schwartz**. Which means the parents do not have a right to know whether the government is putting drugs into the bodies of their children. But the government officially is encouraging parental involvement in the process. OK.

Mr. **Waxman**. The parents do not have the right, absolute right to supersede all other rights.

Ms. **Gasper**. Mr. Waxman, on a different point than what we should or should not do with parents. There is a problem in the actual operation of title X program that it may behoove Congress to address. Let me give you an example.

There are family planning clinics out there across the country and they provide services confidentially to minors. Clinic personnel expressed concern that pimps are arranging access to title X services for minor children so they can go out on the streets and not get pregnant.

Mr. **Waxman**. I would like to receive evidence of this. We are going to leave the record open. I don't want—we really must go on.

We have other witnesses to hear from. If you have something on this, submit it in writing and we will put in the record. I want to see evidence because we certainly would not want that to be.

Ms. **Gasper**. I recommend you modify title X so there has to be reporting to local child protective agencies, so that that can be followed up.

Mr. **Waxman**. I would be interested in seeing that. I may end up agreeing with you.

Mr. Nielson.

Mr. **Nielson**. I have one question, a basic question. It seems to me and I hope this isn't misinterpreted, it seems to me if a woman becomes pregnant, she has already made the decision.

Why should she go to a family planning unit under those circumstances, if she is already pregnant and has already made the decision to have the baby, or to at least to become pregnant, and, if so, why does she need to be involved in a family planning clinic in the first place?

Mr. SCHWARTZ. Is this directed to anyone, sir?

I would volunteer to start out. A woman might find herself in a family planning clinic because she doesn't know she was pregnant before she came in.

At that point, she does not need the services of the family planning clinic. She needs the services of someone who can manage her pregnancy and the new regulations require that title X recipients refer her to such agencies.

Just as if they found by accident that she had a heart problem, they would not try to diagnose or treat that heart problem. They would refer her to someone who could competently take care of it.

Mr. NIELSON. You would say she doesn't need to be in the family planning clinic if she is pregnant?

Mr. SCHWARTZ. Well, if she is pregnant she ought to be referred somewhere else because she is no longer in the realm of needing family planning services.

Mr. NIELSON. Anything else on that Dr. Glasnow; do you have any comment?

All right, I have several more questions I would like to submit for the record. I appreciate your coming. Thank you very much.

Mr. WAXMAN. We will provide an opportunity for members to submit questions in writing and get responses to them for the record.

I will leave the record open for questions to all three panels and the next two and for other members to make statements.

I want to do this for the record so it will be clear. We have unanimous consent for that purpose.

Ms. GASPER. This is another area where we have agreement: improved data collection. I can verify that when I was the DASPA, I attempted to improve the data collection, because we need to know whether or not title X works. I am reasonably confident the current DASPA supports your data collection efforts but there is a bureaucratic difficulty.

Mr. WAXMAN. We would be happy to discuss those proposals further and look for other areas of agreement as we work through the legislation.

Mr. GLASNOW. One clarification. If you think that HHS already has the authority for two of those new initiatives in your legislation, we would assume that you would not object to amendments saying that the provisions don't grant any more authority there.

Mr. WAXMAN. Don't grant any?

Mr. GLASNOW. Additional authority. In other words——

Mr. WAXMAN. I would be receptive to that. Let's look at it because we are not planning to change the law in that regard.

We should, if that is our intent, we should have that cleared up so you don't believe we are changing the law.

Thank you.

We are going to break until 2 o'clock. We will then return to this room and complete the testimony.

[Whereupon, the committee recessed until 2 p.m., the same day.]

AFTER RECESS

Mr. **Waxman**. The meeting of the subcommittee will come back to order.

Each member of the next panel of witnesses is or represents a provider of title X family planning services. Each of them has first-hand experience with the program and its operations.

Dr. Anita L. Nelson is a member of the American College of Obstetricians and Gynecologists and assistant professor of obstetrics and gynecology at Harbor-UCLA Medical Center. She is also medical director of both the Women's Health Care Clinic and the Nurse Practitioner Training Program at UCLA.

Ms. Peggy Jarman is the executive director of Planned Parenthood of Kansas.

Mr. Walter Klausmeier is the executive director of Family Health Services, Inc., of Centre County, PA. And, finally, from Chicago, is Ms. Barbara Waggoner, who is director of the ambulatory women's health care programs at the University of Illinois, College of Medicine.

I am pleased to welcome each of you to our hearing today.

We have your prepared statements, which will be made part of the record in full. We would like to ask you, if you would, please, to summarize those statements or otherwise limit your oral presentation to us to 5 minutes.

Dr. Nelson.

STATEMENTS OF ANITA L. NELSON, MEMBER, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS; PEGGY JARMAN, EXECUTIVE DIRECTOR, PLANNED PARENTHOOD OF KANSAS; WALTER W. KLAUSMEIER, EXECUTIVE DIRECTOR, FAMILY HEALTH SERVICES, INC. OF CENTRE COUNTY, PA; AND BARBARA WAGGONER, DIRECTOR, AMBULATORY WOMEN'S HEALTH CARE PROGRAMS

Ms. **Nelson**. Thank you.

Good afternoon, Mr. Chairman.

As a practicing obstetrician-gynecologist in a title X program, I am very pleased to be here today in support of this important legislation.

Dr. Fox has already highlighted for you the importance of title X programs in preventing infant mortality and morbidity and in providing primary health care services to many indigent patients.

In addition to the family planning services we are providing, each clinic also provides these health care services. When a patient comes into one of my clinics, she receives a complete examination. These simple maneuvers often uncover serious medical problems. Last month we had a 26-year-old woman who came into our clinic who had missed several months periods. We found out she wasn't pregnant and looked into it and found she has a brain tumor. Because we uncovered this problem early, she will be able to have good treatment and her prognosis is very healthy. This same woman's Pap smear results came back and told us she had a precancerous lesion on her cervix. We have treated this problem and have maintained her potential for having children in the future if she so desires.

This is not an unusual case. Many women come into our clinic as entry points into the medical health care system. Each week we discover dozens of women who have these cervical problems. We also treat women for bladder and vaginal infections and a whole array of sexually transmitted diseases.

During her visit in our clinic, each patient also receives vital information and education just about basic health issues. These things she does not have access to in other places. She receives information and understanding she can take home to help the health not only of herself but also of other members of her family.

As a physician, I must counsel each woman fully regarding her choices and options about any medical problem she has. It troubles me greatly that the administration is attempting to eliminate abortion counseling and referrals within title X clinics. This is in conflict with the ACOG standards.

When a patient comes into my clinic and is faced with an unintended pregnancy, I explain all of her options open to her. For instance, she may continue the pregnancy, carry to term and deliver and take the baby home with her. She may continue the pregnancy, carry to term, deliver and offer the baby for adoption. Or she may elect to terminate the pregnancy. After I explain each of these options to her and answer her questions, it is she who makes the final decision.

Denying a patient information that is pertinent to her care is in clear violation of her rights to be fully informed. These regulations endanger the patient's health by delaying her access to providers who can give her the services she desires. They also place the health care provider at additional risk for malpractice because of the failure to inform the patient fully of all of her options.

These regulations will only serve to discourage more providers from entering the program. If you have fewer providers, fewer family planning services will be available. The result will be more unwanted pregnancies and more abortions.

The rate of adolescent pregnancy in this country is alarming. In my practice, there are adolescents who are 10, 12, 13 years old who come in pregnant. It has been said that access to contraceptive services increases the rate of sexual activity among teenagers. I can tell you this is just not true. Women very rarely come to our clinics before they start intercourse. It is typically 6 months, 8 months, 10 months before they come into our clinics, and the reason they come there for the first time is to get a pregnancy test.

The teenagers delay seeking help. Why? There are several reasons for it, but one that has drawn a particular amount of attention is the concern that they have that they may be discovered by their parents.

I always encourage family involvement whenever it is feasible, but I strongly oppose mandatory parental consent or notification because sometimes it is inappropriate. For example, many teenagers these days are victims of sexual abuse, particularly the young ones, oftentimes by a family member. Requiring consent in these cases would expose the young woman to more violent reprisals.

In my area, many of the teenagers are runaways and they are working the streets for survival. To require them to have parental consent would not only be impossible but would also result in more unwanted pregnancies and add to their problem list.

Now, I am not saying title X is going to solve a lot of social problems. All I am saying is it offers women who have these significant problems already, a chance to avoid unwanted pregnancies.

Lack of contraceptive research and development in this country is also a very big problem. All the current devices we have available were developed based on basic research done in the 1960's and maybe the early 1970's. Unless we do more R&D, we are going to find ourselves limiting our future options.

One other important area covered in this legislation is the provision for increased training of nurse practitioners. Graduates for our program serve in rural areas all over the country. They serve on Indian reservations and in inner cities and many places where there are few, if any, providers who are able to care for indigent patients.

In conclusion, I urge prompt reauthorization of this important public health program. I encourage the members of the subcommittee to maintain the medical integrity of the program by opposing any amendments which would mandate parental consent or eliminate abortion counseling or referrals within the title X clinics.

I will be pleased to answer any questions.

Thank you.

[The prepared statement of Ms. Nelson follows:]

STATEMENT

of

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Mr. Chairman, Members of the Subcommittee, I am Anita L. Nelson, MD, a member of the American College of Obstetricians and Gynecologists (ACOG) and Assistant Professor of Obstetrics and Gynecology at Harbor-UCLA Medical Center located in Torrance, California. I am also the Medical Director of the Women's Health Care Clinic and the Nurse Practitioner Training Program, both of which are located at the Medical Center. The Women's Health Care Clinic is funded through Title X and serves primarily indigent patients. I am also the recipient of one of five Title X nurse practitioner training grants. Students enrolled in this program receive their clinical training at the Women's Health Care Clinic.

I appreciate this opportunity to appear before you on behalf of ACOG to discuss the reauthorization of Title X and the related issue of the appropriate federal role in supporting family planning services and population research. Title X of the Public Health Service Act provides voluntary family planning services for nearly 5 million women annually to help them avoid unintended pregnancy. Most women can become pregnant from the time they are teenagers until they are in their late 40s or in some instances, their early 50s. This means that for 30 to 40 years of the normal woman's average lifetime she can become pregnant. My comments will focus on the benefits of family planning services, especially to teenagers, counseling regarding options, and the contraceptive initiative included in the reauthorization measure.

BENEFITS OF FAMILY PLANNING

Effective family planning has been positively correlated with a reduction in infant mortality and low birthweight, a leading cause of infant mortality. The relationship between low birthweight and infant mortality is well-documented in the report Preventing Low Birthweight issued by the Institute of Medicine (IOM) in 1985. Infants weighing 3,000 to 3,500 grams, or 6.6 to 7.8 pounds, experience the lowest mortality rates. The mortality rate increases rapidly with decreasing birthweight particularly for those infants who weigh 2,500 grams (5.5 pounds) or less. Most infants who weigh 1,000 grams (2.2 pounds) or less die. The majority of these infant deaths occur during the neonatal period, that is, the first month of life. In addition to increasing the infant mortality rate, low birthweight also increases the rate of morbidity in infants. Several health problems have been associated with low birthweight including neurological abnormalities such as cerebral palsy and an increased risk of developing respiratory tract conditions.

Several risk factors have been identified that contribute to low birthweight infants. These include certain chronic maternal illnesses, smoking, moderate to heavy alcohol use and drug abuse, poor nutritional status, and susceptibility to infections such as rubella. Other risk factors include childbearing at an early or late age (under 17 or over 34), a very short interval between pregnancies, and a large number of births. It is possible for the health care provider to identify many of the risk factors associated with low birthweight in a woman before she becomes pregnant. Many of these risks can be reduced through appropriate education. In particular, the risk factors associated with timing and number of births can be reduced by effective family planning which can either prevent pregnancy or help to time the occurrence of a pregnancy. The IOM report recommended that "family planning services should be an integral part of overall strategies to reduce the incidence of low birthweight in infants." The need to educate women and teenagers about human reproduction and the risk factors that contribute to infant mortality is also recommended in the IOM report. Healthy Children: Investing in the Future, a report recently issued by the Office of Technology Assessment, also acknowledged the role of family planning in reducing the infant mortality rate and low birthweight.

Several studies indicate that there is an unmet need in this country for contraceptive services especially among teenagers and low-income women. The IOM report recommended the federal subsidization of family planning services to meet this need through programs such as Title X. My experience with the Title X program indicates that it is well-designed to target low-income women and teenagers, both populations at high risk for poor pregnancy outcome. In addition to reducing risk factors associated with low birthweight and infant mortality through the provision of family planning services, Title X clinics provide other beneficial health services to women and teenagers. These include preventive health measures such as screening for cervical cancer and sexually transmitted diseases such as AIDS and Chlamydia. Among the target groups of women involved, such diseases may not be diagnosed in their early stages if the patients did not visit a Title X clinic for contraceptive services.

SERVICES FOR TEENS

The United States has the highest rate of teenage pregnancy in the developed world. For example, it is twice as high as the rates found in Great Britain, France and Canada. In 1984 there were over one million adolescent pregnancies in the United States. Of these pregnancies, 470,000 resulted in live births, 400,000 were pregnancy terminations, and 134,000 were miscarriages. By age 18, 2 out of 10 adolescents have had a pregnancy. By age 20, 4 out of 10 adolescents have had a pregnancy. Although the overall pregnancy rates for women aged 15 to 19 years rose from 1970 to 1980, there was a slight decline in pregnancy rates for this age group by 1984. However, the pregnancy rate for adolescents 14 years old and under increased slightly in 1983.

As noted in the IOM report, the rates of maternal mortality and morbidity and the risk of giving birth to a low birthweight infant are considerably higher among teenage mothers. The available evidence shows that infants of teenage parents are much more likely to be of low birthweight and to die than are those born to mothers over the age of 20. In addition to medical problems, teenage pregnancy and childbearing are associated with a number of social and economic problems. Most adolescents are ill-prepared emotionally or financially for the responsibilities of parenthood. The Center for Population Options recently reported that the United States spent $18 billion in 1986 in public assistance payments to households where the mother was a teenager when her first child was born.

Both the personal and the public costs of early childbearing stretch across decades and generations.

It is estimated that 2.4 million teenagers under the age of 18 are at risk of pregnancy because they are sexually active. Statistical studies indicate clearly that an adolescent population that is sexually active at an early age is the least inclined to use the most effective forms of contraception. During the 1970s premarital sexual activity among young women 15 to 19 years of age increased by 67 percent. Today, six of every ten teenage women are sexually active by the age of 19, and four of every ten are sexually active by the age of 17.

Some argue that access to contraceptives increases the rate of sexual activity among teenagers. This is simply not true. Female adolescents generally wait approximately six months to one year after the initiation of sexual activity to seek medical advice. Often, this is to request a pregnancy test. More than 85 percent of teenagers first visiting family planning clinics are already sexually active, and 50 percent have been so for nine months or more. Research indicates that fifty percent of all teenagers do not use contraceptives during their first sexual experience. Twenty percent of first pregnancies occur during the first month after the initiation of sexual activity. Fifty percent occur during the first six months.

Adolescents demonstrate a high utilization of abortion to resolve pregnancy. Of the one million adolescents who become pregnant each year, slightly less than 50 percent choose abortion. Adolescent women whose first pregnancy ends in abortion usually practice contraception more vigilantly thereafter and are only half as likely to become pregnant again within a year as are those whose first pregnancy ended in a live birth. Clearly, the availability and effective use of contraception, particularly among teenagers, is the most effective way to prevent unintended pregnancy. This has been documented in recent studies including one published in the October 16, 1987 issue of the Journal of the American

Medical Association where the Centers for Disease Control reported that the teenage birth rate declined for the first time in 1983 and again in 1984. Since the abortion rate has levelled off and there is no reduction in the percentage of teenagers having sexual intercourse, the authors of the study concluded that the reduction in birth rate is attributable to "...behavioral factors that reduce the likelihood of becoming pregnant, such as increased use of contraceptives."

Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing, a National Academy of Sciences' report published in 1987, also concluded that "the most effective intervention for reducing early unintended pregnancy in sexually active teenagers is diligent contraceptive use." The report recommends continued public support for the provision of contraceptive services to adolescents and cited Title X as one important example of such a program. Title X clinics can play an important role in education and outreach to the teenage population.

As a practicing obstetrician-gynecologist, I provide health care services to sexually active women during their teen years as I would any patient, regardless of age or emancipation status. This is consistent with the policy of the American College of Obstetricians and Gynecologists (ACOG) which recommends that sexually active teenagers of any age, and all those aged 18 years or over, be encouraged to have yearly pelvic examinations. The sixth edition of ACOG's Standards for Obstetric-Gynecologic Services states: "The sexually active adolescent female deserves special attention because of the high incidence of unintended pregnancy in this population. The gynecologist should attempt to ensure that individuals exposed to the risk of unwanted pregnancy have access to the most suitable methods of contraception."

Studies indicate that one of the major causes for delay by adolescents in seeking contraception is fear of parental discovery. As a physician who works with adolescents, I encourage family involvement when feasible. However, the health care provider's primary duty is to the patient. Adolescents should not be denied care and services on the basis of mandated parental consultation. Mandated parental notification or consent may subject the patient to family friction or abusive behavior. Teenagers who do not wish to involve their parents will not seek contraceptive services, thereby serving only to increase the rate of teenage pregnancy and ultimately the number of abortions. During the debate on the parental notification rule issued by the Department of Health and Human Services in 1982 and later overturned by the District of Columbia Court of Appeals, several clinics reported a drop in the number of teenage patients. Although most states normally require parental consent when minors obtain medical care, twenty-nine states and the District of Columbia have legislated the right of minors to obtain contraceptive information and care by their own consent.

Mandatory parental notification or consent also violates the confidentiality of the patient/physician relationship. The argument has been made that parents should be notified because of the health risks of prescription contraceptives. However, the health risks of pregnancy far exceed the health risks of effective contraception, especially among adolescents. For example, a sexually active adolescent is five times more likely to die of conditions related to pregnancy than when using oral contraceptives. For these reasons, I urge the Subcommittee to oppose any amendments which would mandate parental notification or consent.

OPTIONS COUNSELING

In recent years, there have been several attempts through legislation and regulation to prohibit counseling and referral for abortion services in programs receiving federal family planning funds. As federal funding of abortion is already prohibited by law, such attempts go beyond this restriction and are aimed at restricting the flow of information between a patient and her physician. A prohibition on the content of counseling between the patient and her physician is contrary to medical standards and severely erodes the patient's right to informed consent. As a physician, I respect and value my responsibility to counsel women fully regarding their choices and options of medical treatment.

To eliminate any counseling or referral for abortion within the Title X program violates a basic medical principle -- the duty of the health care provider to provide all pertinent information to the patient as well as a patient's right to give informed consent. Informed consent is a legal doctrine that requires the physician to obtain consent from a patient before a medical treatment is rendered. It is a process of education and discussion which requires active interchange between the physician and the patient. The physician must provide an explanation to the patient which should include the diagnosis, a description of the procedure to be used, the risks and benefits, the expected outcome, and a description of any alternative courses of treatment. Throughout the discussion, the health care provider should encourage questions to assure that the patient fully understands the information provided.

Good health practice demands open communication between health care professionals and their patients. When we are prevented from communicating honestly and adequately with those we serve, patients do not receive the best health care. All patients have the right to decide what medical care they wish to receive. Patients can make this choice only after being fully informed by the health care provider of the risks and benefits of *all* available options.

The sixth edition of ACOG's *Standards for Obstetric-Gynecologic Services* states: "In the event of an unwanted pregnancy, the physician should counsel the patient about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy." These standards are consistent with the current program guidelines for Title X. I urge the Subcommittee to oppose any amendments which would restrict the content of counseling between a patient and her health care provider.

CONTRACEPTIVE RESEARCH

Included in the Title X reauthorization measure is an initiative on contraceptive research. The need for safer and more effective methods of contraception is more important than ever. I urge the Subcommittee to support this initiative.

Women today have fewer contraceptive choices in large part due to the current climate surrounding product liability. This climate has affected the availability of contraceptives on the market as well as technological innovation in this area. In 1986, the G.D. Searle Company withdrew from the market the Copper-7 IUD, used by over two million women in the United States. Prior to 1986, several other IUDs were also withdrawn. Searle's decision to remove the Copper-7 from the market was reached because of the high costs of defending liability suits and the inability to obtain adequate insurance, despite continued Food and Drug Administration (FDA) approval of the product. Although Gyno Pharma Inc. recently announced it will market the Copper T380A IUD, first approved by the FDA in 1984, this is the exception rather than the rule.

Recently the Supreme Court refused to review and thereby let stand a lower court decision in Ortho v. Wells, which awarded $4.6 million in damages against the Ortho Pharmaceutical Company. The suit was filed by a woman who became pregnant while using contraceptive jelly and later claimed that it caused severe birth defects in her infant. The decision in this case is particularly disturbing because it contradicts the available scientific evidence. It is of great concern that pharmaceutical manufacturers of spermicides may withdraw such products from the market if they are faced with the costs of defending additional suits involving huge awards. This would have a devastating effect on contraceptive availability of the spermicide nonoxynol-9, which is used in several birth control methods, including foams, creams, alone or with a diaphragm, and with the contraceptive sponge.

The liability crisis has also affected technological innovation. Traditionally, contraceptive research and development have been carried out by the pharmaceutical industry, the federal government, and non-profit organizations. Several manufacturers are no longer carrying out such research and development due to the specter of liability suits, low return on their investments, and the long FDA approval process. These same factors also hamper small firms from carrying out innovative studies. Research in this area now falls almost exclusively to the federal government and non-profit organizations. I commend the Chairman and the Ranking Minority Member for recognizing the need for additional contraceptive research and development to assure that American women have access to the safest and most effective contraceptive methods.

CONCLUSION

In conclusion, I support prompt reauthorization of the Title X family planning program and urge the Subcommittee to recognize the special needs of adolescents. I also urge the Subcommittee to maintain the medical integrity of the program and to oppose any amendments requiring parental notification or consent or restricting the content of counseling between the health care provider and patient.

I will be happy to answer any questions.

Mr. **WAXMAN**. Thank you.

Ms. Jarman.

STATEMENT OF PEGGY JARMAN

Ms. **JARMAN**. Chairman Waxman, it is an honor to testify before this subcommittee in support of H.R. 3769. We are grateful for this subcommittee's unwavering support of the title X program and we are very proud of our Kansas contingent, Congressman Whittaker, who has been a long-time friend of our program.

Planned Parenthood supports H.R. 3769, a 3-year reauthorization of the title X family planning program. Since 1970, title X has served as the backbone of our national family planning clinic network that provides medical and education services to over 5 million low-income women and teenagers in 4,500 local clinics around the country. While the primary focus of title X is contraception, title X-supported clinics offer a range of basic preventive health services and are often the first place low-income women, and especially teenagers, receive formal medical care.

Moreover, the title X family planning program is the only major Federal health program that by design aims to reduce the need for abortion. More than half of the approximately 6 million pregnancies that occur each year are unintended, and half of those unintended pregnancies end in abortion. It is a terrible irony that the interest groups that most strongly oppose abortion are the very ones who have tried repeatedly to dismantle the national family planning program.

There has been a lot of discussion recently about the problem of adolescent pregnancy, and I would like to spend a minute talking about the importance of adolescent services under title X.

A recent poll by Louis Harris Associates found that 84 percent of Americans believe teen pregnancy is a serious problem. While the solutions to this problem are complex, a panel of experts convened by the National Academy of Sciences concluded last year that diligent use of contraception by sexually active teens is the surest strategy for prevention of teen pregnancies. One of the Academy's specific recommendations is the reauthorization of the title X program.

Adolescent pregnancy is also a major concern to us in Kansas. A recent study by graduate students in maternal and child health at Wichita State University calculated the cost of adolescent pregnancy to the State of Kansas. The study revealed that Kansas could have saved $19.14 million in 1 year if the adolescent mothers had delayed having children until they were 20 years of age or older.

I would like to submit a summary of that study for the record.

In 1986, with the encouragement of the Kansas Department of Health and Environment, we opened a new clinic in Cowley County, the county with the highest adolescent pregnancy rate in our State: 86 percent of the patients we see in this clinic have incomes below 150 percent of the poverty level; 37 percent of the clients are under the age of 18. Two-thirds of our patients there are adults.

When our original title X grant of $6,000 proved insufficient to meet the needs of our patients, the majority of whom were poor and unable to pay for services, the State provided an additional $10,000 in title X funds. Without that support we would have been forced to discontinue services in Cowley County.

In addition to this clinic, Planned Parenthood of Kansas operates clinics in two additional counties. We provided medical services to 5,800 patients in 1987. For many of these patients, Planned Parenthood of Kansas represented their entrance into the health care network.

We are proud to be part of the title X provider network in Kansas, although we are by no means the largest provider. In fact, over 90 percent of the nearly $1.24 million which title X sends into Kansas supports public health programs that make family planning services available to low-income women throughout the State.

It is critical to ensure adequate funding levels for the title X program if we are to meet the demands facing the program today and the new challenges on the horizon. In 1981 family planning, along with most other domestic health programs, took a drastic 22 percent cut in appropriations. This year's appropriation of $136.4 million, which represents a $6 million cut from last year, is still more than $30 million below fiscal year 1981's level, not adjusting for inflation.

It is time that we again think of family planning as a basic public health service, a part of our overall effort to improve maternal and child health, and not as another political battleground on which to debate the issue of abortion.

We urge prompt passage of H.R. 3769, and once again I thank the Chair and the subcommittee for this opportunity to testify.

[The prepared statement of Ms. Jarman and attachment follow:]

TESTIMONY OF PEGGY JARMAN, EXECUTIVE DIRECTOR

PLANNED PARENTHOOD OF KANSAS

Chairman Waxman, members of the subcommittee, I am Peggy Jarman, Executive Director for Planned Parenthood of Kansas. With your permission, I would like to submit testimony on behalf of Faye Wattleton, President of Planned Parenthood Federation of America, for the record.

It is an honor to testify before this subcommittee in support of H.R. 3769. We are grateful for the subcommittee's unwaivering support of the Title X program and we are very proud of our Kansas contingent, Congressman Whittaker, who has been a long-time friend of our program.

Planned Parenthood supports H.R. 3769, a three-year reauthorization of the Title X family planning program. Since 1970, Title X has served as the backbone of our national family planning clinic network that provides medical and education services to over five million low-income women and teenagers in 4500 local clinics around the country. While the primary focus of Title X is contraception, Title X-supported clinics offer a range of basic preventive health services, and are often the first place low-income women -- and especially teenagers-- receive formal medical care.

Moreover, the Title X family planning program is the only major federal health program that by design aims to reduce the need for abortion. More than half of the approximately six million pregnancies that occur each year are unintended, and half of those unintended pregnancies end in abortion. It is a terrible irony that the interest groups that most strongly oppose abortion, are the very ones who have tried repeatedly to dismantle the national family planning program.

There has been a lot of discussion recently about the problem of adolescent pregnancy, and I would like to spend a minute talking about the importance of adolescent services under Title X. A recent poll by Louis Harris Associates found that 84% of Americans believe teen pregnancy is a serious problem. While the solutions to this problem are complex, a panel of experts convened by the National Academy of Sciences concluded last year that diligent use of contraception by sexually active teens is the surest strategy for prevention of teen pregnancies. One of the Academy's specific recommendations is the reauthorization of the Title X program.

Adolescent pregnancy is also a major concern to us in Kansas. A recent study by graduate students in maternal and child nursing at Wichita State University calculated the cost of adolescent pregnancy to the state of Kansas. These costs included direct and administrative cost for AFDC, food stamp allocations and Medicaid outlays. The study revealed that Kansas could have saved $19.14 million in one year if the adolescent mothers had delayed having children until they were 20 years of age or older. The authors of the study conclude that "strategies that focus on prevention of adolescent pregnancy are needed and could avert negative social, educational, and economic consequences to the mother and her child, as well as high expenditures of public funds to support adolescent families." I would like to submit a summary of the study for the record.

In 1986, with the encouragement of the Kansas Department of Health and Environment, we opened a new clinic in Cowley County, the county with the highest adolescent pregnancy rate in our state. Eighty-six percent of the patients we see in this clinic have incomes below 150% of the poverty level. Thirty-seven percent of the clients are under the age of 18. When our original Title X grant of $6,000 proved insufficient to meet the needs of our patients -- the majority of whom were poor and unable to pay for services -- the State provided an additional $10,000 in Title X funds. Without that support we would have been forced to discontinue services in Cowley County.

In addition to this clinic, Planned Parenthood of Kansas operates clinics in two additional counties. We provided medical services to 5800 patients in 1987. For many of these patients, Planned Parenthood of Kansas represented their entrance into the health care network. In addition to our medical program, we served 10,500 Kansans through our educational programs for schools and community groups. We work closely with school districts to help them comply with the recently mandated sexuality education requirement passed by the State Board of Education. We also work extensively with parent groups, and offer a very popular workshop entitled, "Self-Esteem for Teens."

We are proud to be part of the Title X provider network in Kansas, although we are by no means the largest provider. In fact, over ninety percent of the nearly $1.24 million Title X sends into Kansas supports public health programs that make family planning available to low-income women throughout the state.

Mr. Chairman, Planned Parenthood supports the reauthorization of the Title X program, including the contraceptive research initiative and the expansion of information and education activities. We need to expand our efforts to find more safe and effective methods of contraception to further reduce the need for abortion. And we need to do more -- not less -- to reach out to adolescents with information and education to help them make responsible decisions about their sexuality and their futures.

But most importantly, we need to ensure adequate funding levels for the Title X program if we are to meet the demands facing the program today and the new challenges on the horizon. In 1981, family planning, along with most other domestic health programs, took a drastic 22 percent cut in appropriations. This year's appropriation of $136.4 million -- which represents a $6 million cut from last year -- is still more than $30 million below FY 1981's level, not adjusting for inflation.

It is time that we again think of family planning as a basic public health service -- a part of our overall effort to improve maternal and child health -- and not as another political battleground on which to debate the issue of abortion. We urge prompt passage of H.R. 3769, and once again, I thank the Chair and the subcommittee for this opportunity to testify.

The Public Cost of Adolescent Pregnancy in Kansas

By: Marjory K. Waterman, R.N., B.S.N., Virginia Lynn Scott, R.N., B.S.N. and Francine H. Nichols, R.N.C., Ph.D.

Marjory Waterman

Virginia Lynn Scott

Francine H. Nichols

Adolescent pregnancy and parenthood have increased steadily in the last twenty years, particularly among unwed and younger adolescents. Each year more than one million adolescents become pregnant. Kansas ranks nineteenth in the nation in rate of white adolescent pregnancy and seventh in black adolescent pregnancy (Singh, 1986). If present statistical trends continue, more than one third of the girls who are now fourteen years old will become pregnant at least once before they reach the age of twenty. Adolescent mothers are currently rearing 1.3 million children with an additional 1.6 million children less than five years of age living with women who were adolescents at childbirth (Alan Guttmacher Institute, 1981).

Pregnancy affects not only the individual adolescent and her infant but society as a whole. The adolescent mother is more likely to discontinue her education and is likely to have more children than her peers who delay childbearing until at least twenty years of age. Furthermore, adolescent pregnancy and parenthood are linked to increased marital instability, decreased participation in the labor force, decreased earnings potential, increased dependence on public assistance and increased poverty (Chilman, 1980; Dryfoos, 1982; Furstenberg, 1981; Kansas Action for Children, 1985; National Research Council, Panel on Adolescent Pregnancy and Childbearing, 1987).

In 1985 there were 39,418 live births in Kansas and 4,492 of these births were to adolescents. Of these adolescent births, 3,519 were first births (Kansas State Department of Health and Environment, 1986). According to a state wide survey of Kansas Aid to Families with Dependent Children (AFDC) clients, 52 percent of families receiving AFDC were headed by women who had their first child while an adolescent (Kansas Department of Social and Rehabilitative Services, 1985). The purpose of this study was to determine the cost of adolescent pregnancy to the state of Kansas for the year 1985.

Literature Review

Several previous studies have been conducted to estimate the public costs of adolescent childbearing. While these studies have used different methodology, the majority have considered public costs arising from AFDC, Medicaid, food stamps, and social services in determining the cost of adolescent pregnancy. The focus of these studies has ranged from an exploration of costs at a national level (SRI International, 1979; Wertheimer & Moore, 1982; Burt, 1986) to a narrower focus on a single state, county, or comunity (Block & Dubin, 1981; Walentik, 1983).

The SRI International study (1979), with its clearly defined assumptions and methodology, has to date served as a model for later studies. Estimates were made of single birth costs and single cohort costs for adolescent pregnancy in 1979 and expressed as fullcosts. Later studies (Walentik, 1983 and Burt & Haffner, 1986) expressed their findings using marginal costs, that is, the savings possible assuming that a certain percentage of adolescents would need public assistance as adults, regardless of when they delivered a child.

Walentik's (1983) study of the economic cost of adolescent pregnancy to St. Louis, Missouri was very similar to the SRI International study. Exceptions were the use of an 18 year projection for single cohort costs, the calculation of costs based on total births to adolescents rather than first births only, and the calculation of marginal rather than full cost savings possible with the prevention of adolescent pregnancy. In 1986, Burt and Haffner developed an instrument to estimate the cost of adolescent pregnancy in the United States or a locality within the United States. Previous studies were used as a basis for determining the assumptions of the study as well as the costs used to arrive at estimates of the public cost of adolescent pregnancy (Burt & Haffner, 1986). Applying this formula to national 1985 data yielded an average **single birth cost** of $13,902, a **single year cost** of $16.5 billion and a **single cohort cost** of $5.2 billion. It was estimated that if all adolescent births in the United States in 1985 had been delayed, there would be a **savings of $2.1 billion**.

Methodology

The Burt and Haffner (1986) instrument was used to calculate the public cost of adolescent pregnancy to Kansas in 1985. This instrument is based on certain assumptions: (1) greater fertility among women with an early first birth; (2) the increased potential for dependence upon public assistance during the women's childbearing career; (3) the largest public assistance programs reaching the largest number of families are AFDC, Medicaid, and food stamps (Burt & Haffner, 1986).

The tool includes only first births, making numerical adjustments for the documented likelihood of greater fertility among women with an early first birth. Twenty year projections for public assistance are based on research indicating that fifty percent of adolescents will have a second birth within two years of the first. Thus there is an increased probability that the family will remain on public assistance beyond the eighteenth birthday of the first child (Burt, 1986).

The following data were collected from State agencies using the Burt and Haffner tool: first live births to adolescents in three age categories, 14 years or younger, 15-17 years, and 18-19 years, and direct cash and administrative costs for AFDC, food stamp allocations, and Medicaid outlays. The data were analyzed using Burt and Haffner's adaptation of the Lotus 1-2-3 computer program to calculate certain cost categories and model (with discounting) the future year costs of adolescent pregnancy. Calculated costs are defined as follows: (1) single birth cost — the public cost for a single family begun by an adolescent birth for twenty years following that birth; (2) single year cost — the public cost in a single year to support all families begun by a birth to an adolescent in that year; and (3) single cohort cost — the public cost for all families begun by a teen birth in a single year for the twenty years that the family may require public assistance. Calculations were also made of the potential cost savings realized if all adolescent births were delayed. This figure was based on research by Wertheimer and Moore (1982) who noted that even if all adolescent births were delayed, many low income families would still be dependent on public assistance.

Estimates of Public Costs in Kansas: 1985

Single birth costs: The average single birth cost of **$13,600** for the state of Kansas was slightly lower than the national average of $13,902 (Burt, 1986). The average single birth costs for specific age groups were as follows: for mothers under fourteen the cost for Kansas was $17,670 as compared to a national average of $17,724 (Burt, 1986); for mothers ages fifteen to seventeen the cost was $17,636 as compared to a national average of $17,689 (Burt, 1986); and for mothers between eighteen and nineteen years old the cost was $11,174 as compared to a national average of $11,214 (Burt, 1986). If these adolescents had not given birth to an infant until they were at least twenty years old the state of Kansas would have saved an average of $5,340 for each birth as compared to $5,560 nationally (Burt, 1986).

Single year costs: In 1985, the state of Kansas spent **$143.92 million** on families that were started when the mother was an adolescent. This figure includes actual payments as well as administrative costs associated with AFDC, Medicaid, and food stamps.* This estimate reflects only the minimal public outlays for adolescent pregnancy in that it does not include frequently used public services such as housing, special education, child protection services, foster care, day care, and other social services. These are average costs for families begun by an adolescent birth. Two out of three adolescent mothers do not receive public assistance; thus the actual public cost of a single birth to an adolescent who does receive assistance is considerably higher than the estimated average cost.

Single cohort costs: All Kansas families begun by a first birth to an adolescent in 1985 will cost taxpayers $47.86 million over the next twenty years. If all adolescent births in Kansas were delayed until the mother was twenty years or older, the potential savings for the state of Kansas would be **$19.14 million** for the entire cohort of adolescents who would otherwise have had a first birth in 1985. This potential savings represents forty percent of the full estimated cohort cost of adolescent childbearing in Kansas.

Implications

Adolescent childbearing results not only in negative social, educational, and economic consequences to the mother and her child, but also in high expenditures of public funds to support adolescent families. Efforts should be targeted toward reducing the incidence of adolescent pregnancy and ensuring adequate support programs and services for pregnant and parenting adolescents. There are three initiatives that have been shown to be effective in reducing the incidence of adolescent pregnancy.

1. Family Life Education Programs (sex education) that encourage adolescents to delay sexual activity as well as emphasizing their responsibility if they decide to become sexually active.
2. School Based Health Clinics that provide both health care and information about family planning.
3. Family Planning Clinics that are located near schools and are open during the evening hours.

Public health policy is needed to secure funding for the development and provision of these adolescent pregnancy prevention programs as well as for the provision of adequate prenatal and pediatric health care for adolescent families. Nurses and other health professionals can use the data on the economic consequences of adolescent pregnancy in Kansas to actively advocate for increased funding for adolescent pregnancy prevention programs in the State. The execution of rigorously designed research to evaluate the effectiveness of current and future programs, develop a definitive knowledge base and generate new ideas for the prevention of adolescent pregnancy is also essential. The investment now in strategies related to the prevention of adolescent pregnancy as well as support programs for adolescent families can avert social, educational and economic consequences to the adolescent mother and her child as well as high expenditures of public funds to support adolescent families.

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*AFDC and Medicaid programs are funded by a combination of State and federal funds, while the Food Stamp Program is funded solely by federal funds.

Abstract

The purpose of this study was to calculate the costs of adolescent pregnancy to the state of Kansas for the year 1985. The following data were collected from State agencies using the Burt and Haffner tool: first live births to adolescents in three age categories, 14 years or younger, 15-17 years, and 18-19 years; and direct cash and administrative costs for Aid to Families with Dependent Children (AFDC), food stamp allocations, and Medicaid outlays. Data were analyzed using Burt and Haffner's adaptation of the Lotus 1-2-3 computer program. The average single birth cost (public cost for single family begun by an adolescent birth for twenty years following that birth) was $13,600. The single year cost (public cost in a single year to support all families begun by a birth to an adolescent in that year) was $143.92 million. The single cohort cost (public cost for all families begun by a teen birth in a single year for the twenty years that the family may require public assistance) was $47.86 million over the next twenty years. Kansas could have saved $19.14 million if these adolescent mothers had delayed having children until they were twenty years of age or older. Strategies that focus on the prevention of adolescent pregnancy are needed and could avert negative social, educational, and economic consequences to the mother and her child as well as high expenditures of public funds to support adolescent families.

Acknowledgments

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Mr. **Waxman**. Thank you very much.
Mr. Klausmeier.

STATEMENT OF WALTER W. KLAUSMEIER

Mr. **Klausmeier**. Mr. Chairman, other distinguished members of the committee, I am Walter Klausmeier, the executive director of Family Health Services.

I would like to speak in favor of H.R. 3769.

Family Health Services was begun by a group of local concerned citizens in Centre County, PA in 1970. We are a rural health care provider and the cornerstone of our agency is our family planning program. We serve three counties, three rural sites: the town of Philipsburg, which is a small, depressed, coal mining region; State College, which is a town of about 35,000 residents; Bellefonte, which is a typical rural Pennsylvania town of just over 6,000 residents.

Since beginning our program as a family planning program, we have integrated other maternal/child health services around this core program. I think that makes us somewhat unique. Those services are the WIC program—the Women, Infant and Children Nutrition Program—EPSDT; and sexually transmitted diseases testing, where we are providing both treatment and counseling and education to both men and women, and where, very recently, we integrated into that program HIV screening, testing and counseling. We also offer cancer screening tests to our clients, as well as older women. We provide genetic screening services and also an array of educational programs, including prenatal education for pregnant women.

We believe title X has addressed many of the important health issues of our day, such as the prevention of cervical and uterine cancers; decreasing unwanted teenage pregnancy and sexually transmitted diseases; and providing quality, medically supervised family planning services.

We also believe we have lived up to the public trust placed in our agency to provide these services and to the trust of Congress and of your committee in carrying forth this important public health program.

It is interesting to note our experience is different from those of some of the previous witnesses of this morning, in that we have seen both a decrease in birth to teens and a decrease in abortions to teens in Centre County, PA. Birth to teens in a period from 1979 to 1984 has declined by 15 percent and at the same time the abortion rate decreased. It is important to make the distinction that there is a corresponding decrease in the abortion rate as well as the birth to teen rate. As you know, nothing prevents the need for abortion more than good medically supervised family planning services.

We also have noticed that a direct corollary to our decrease in Centre County, PA—one of the Pennsylvania counties—also has occurred in the State. There is a decrease in the age group 15 to 19 in terms of pregnancies and of abortions in that group from 1977 to 1986. That is quite a long period of time, and the numbers have been published by the State health department.

One example of how title X has helped to improve the lives of people in our community occurred recently. One of our nurse practitioners, having received the results of a recent Pap test, noticed an abnormal finding. We then invited the client to return to the clinic for further followup and cervicography. Ultimately, she was referred for a hysterectomy due to carcinoma. This was a tragic story, yes, but this cancer was detected early enough for our client to have a complete recovery.

I think this illustrates well the life benefits of the national family planning program. Helping men and women meet their reproductive health needs continues to be one of our primary goals. Reproductive health care takes many forms at Family Health Services: its annual gynecologic exams, including Pap smears, pelvic exams, breast exams, and other arrays of tests for our clients.

Yet another illustration of title X's impact on rural communities is through the testimony of another client who told us the following family planning success story:

> I am the oldest of eight children raised in a strict Catholic family. My upbringing was steeped in discipline and tradition. My father, being a blue collar worker, and my mother staying at home, we were a typical lower-middle-class family of the 1950s. The first 13 years of my life were spent in a small, rural Pennsylvania town where I attended parochial school for 8 years.
>
> During my first years in junior high school, my family moved to a farm and I finished my education in the public school system. At age 17 I went to the Family Planning Center under much the same circumstances as most of my peers. I was a sexually active teenager not using a method of birth control with any regularity. As I look back on this period of my life, my lack of understanding and education about sex is not only disconcerting but also sadly typical.
>
> There is no doubt in my mind that if family planning had not been available to me, both financially and confidentially, I would have become a pregnant teenager. There was a friend already using the Family Planning Center that encouraged me to visit the clinic. Then I encouraged others who needed the service to do the same. Like most teenagers, I was already having sex before I visited the Family Planning clinic.

We have heard testimony today that indicated this is typical of teens' experience in that they are having sex before they visit a family planning clinic, anywhere from 6 months to 2 years.

Mr. **WAXMAN**. I am going to have to interrupt you.

Mr. **KLAUSMEIER**. May I offer a summary?

Mr. **WAXMAN**. A brief sentence or two.

Mr. **KLAUSMEIER**. This is a typical story of a family planning client. She went on to have several children, to visit the clinic after her children were delivered, and also she used our WIC Program.

So there are a lot of health benefits that accrue to the family planning program and we hope that your bill, H.R. 3769, will be become law.

Thank you very much.

[The prepared statement of Mr. Klausmeier follows:]

TESTIMONY

of

Walter W. Klausmeier
Executive Director
on behalf of Family Health Services, Incorporated
of Centre County, Pennsylvania

Mr. Chairman and Members of the Committee:

I am Walter W. Klausmeier, Executive Director of Family Health Services. On behalf of Family Health Services, I thank you for this opportunity to testify in support of the reauthorization of Title 10 of the Public Health Service Act.

Family Health Services, a non-profit agency, was established in 1970 by a group of citizens of Centre County, Pennsylvania, who were concerned about the lack of comprehensive family planning services in our community.

Family Health Services serves our community through three clinics located in Philipsburg, a small coal mining town of approximately 2,000; State College, a college town of 34,456; and Bellefonte, a typical rural Pennsylvania town of 6,308. As a private non-profit agency, the cornerstone of our organization is our Family Planning Program. Reproductive health exams, breast exams, early cancer screening, pregnancy tests, birth control counseling, infection treatment and genetic screening are some of the many services that are offered at our clinic.

Since our beginning, we have integrated other health services that include our Women, Infants and Children (WIC) nutrition program which provides supplemental foods to pregnant and breastfeeding women, women who have delivered within six months, and children under the age of five who qualify economically and nutritionally. Family Health Services also provides child health screening to those clients on medical assistance through the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT). EPSDT not only provides a basic physical assessment but also includes dental assessments, immunizations, developmental screening and vision testing. Responding to the public health problem of AIDs, we have instituted HIV screening and counseling into our agency. Family Health Services also provides reproductive health services to men. In this regard, we would like to encourage an increase in Title 10 funding for reproductive health services for men.

Family Health Services also provides education to community members through our community education program. Prenatal education classes are available free of charge to pregnant women and their partners with four sets of sessions held a year.

We believe that Title 10 has addressed many of the important health issues of our day such as the prevention of cervical and uterine cancers, decreasing unwanted teenage pregnancy, and sexually transmissible diseases prevention as well as providing quality family planning services. In short, Title 10 has improved the health of our community.

One example of how Title 10 helped improve the health of our community is the story of one of our clients, Joan. Joan first visited Family Health Services several months ago for an annual gynecological exam by one of our nurse practitioners. The results of her pap smear came back abnormal, suggestive of cervical cancer. Joan was referred to see an Obstetrician/Gynecologist at Family Health Services' dysplasia clinic for further evaluation. Using cervicography (the taking of a photograph of the entire cervix) and colposcopy (a viewing of the cervix under magnification with a high intensity light) along with biopsy, our suspicions of cervical cancer were confirmed.

A tragic story, yes. But also one filled with hope because Joan's cancer was detected in the early stages and treated successfully, thanks to newer, more sophisticated techniques and to Title 10, the

National Family Planning Program. Joan is alive today thanks to family planning.

Helping men and women meet their reproductive health needs continues to be one of our primary goals. Reproductive health care takes many forms at Family Health Services. It is annual gynecological exams (like Joan had) including pap smears, pelvic, and breast exams that are invaluable in early cancer detection. It is also contraceptive and sexuality counseling for men and women, tailored to meet each individual's needs.

Yet another illustration of Title 10's impact on rural communities is through the testimony of another client who told us the following family planning success story. I have lived all of my 32 years in Centre County, Pennsylvania. The oldest of eight children, raised in a strict Catholic family, my upbringing was steeped in discipline and tradition. My father being a blue collar worker and my mother staying at home, we were a typical lower-middle class family of the fifties. The first thirteen years of my life were spent in a small rural Pennsylvania town where I attended parochial school for eight years. During my first year in junior high school, my family moved to a farm and I finished my education in the public school system

At age 17, I went to family planning under much the same circumstances as most of my peers. I was a sexually active teenager not using a method of birth control with any regularity. As I looked back on this period of my life, my lack of understanding and education about sex is not only disconcerting, but also sadly typical. There is no doubt in my mind that if family planning had not been available to me both financially and confidentially, I would have been a statistic, a pregnant teenager. It was a friend already using family planning that encouraged me to visit the clinic. Then I encouraged others who needed the service to do the same. Like most teens, I was already having sex before I visited a family planning clinic.

Confidentiality was of great importance to me. Seeing my family physician was not a possibility because he was a friend of the family and surely would have told my parents of my visit. Family Planning offered me the confidentiality that I sought, services at no cost that I could not otherwise have afforded, and much needed education that in my ignorance I did not even know I needed. The staff was always patient, understanding and most of all, professional. They obviously had seen many young women in my situation.

Visits to the family planning clinic were not limited to my teen years. I have utilized its family planning services with the exception of the times that I was pregnant with my two children and during that time I was fortunate to use the Women, Infants and Children program. In addition to contraception and nutritional needs, I have been seen for check-ups and physicals. Even today I am in need of the services that this clinic and others like it provide on a sliding fee scale. Low and moderate income women like me depend on the continued availability of low cost, high quality health services.

I have few financial resources to repay the clinic for the years of service that it has given me. My form of payment has been in service on the clinic board where I have worked to make sure that others in my situation have the same opportunities available that I did.

Having access to family planning services did more than keep me from getting pregnant. It helped to break the poverty cycle in my family. I did not marry too young. I had a chance to work my way through college, being the first female in my family to do so. It enabled me to gain the maturity and confidence to develop into an independent person. Because of family planning services, I chose a husband based on merit and not on fatherhood. I was able to space my children and make sure that they came when we were ready. I see family planning services as a continuum through my life, a real life line.

As I mentioned, I feel my situation was not an exception but the norm. I am confident that having access to family planning as a teenager changed major variables in my life. I am a family planning success story and our family is a stronger family today because of our local clinic.

These stories are compelling ones. Voices crying out above those calling for restrictions, or even an end to these vital services. If our opponents have their way, hundreds of women like these will find their confidentiality threatened, or worse their lives. Title 10 improves the health of our people. Please join with other members of Congress in supporting this noble effort.

Mr. **Waxman**. Thank you.

Ms. Waggoner.

STATEMENT OF BARBARA WAGGONER

Ms. **Waggoner**. Chairman Waxman and members of the committee, I am pleased to be here today to testify in support reauthorization of the title X program.

I am here to talk to you about hospital-based clinics and title X family planning programs in Illinois.

I work for the University of Illinois at Chicago, which has had a title X-funded program since 1980. In addition to ours, there are seven hospital-based programs in Chicago in Cook County. They have made a very important contribution to family planning in the State of Illinois.

Three of the eight hospital-based programs are located in Regional Perinatal Centers, which means that we provide tertiary prenatal care and delivery to women with high-risk pregnancies. Many of these women come from the 19 Chicago Community Areas which have been targeted by Governor Thompson's Infant Mortality Reduction Initiative.

In our continuing fight to lower infant mortality rates, it is essential that women who have just had a high-risk pregnancy have access to education and subsidized family planning services.

In addition, the low-income women in the hospital-based programs tend to use the family planning clinic as their entry point into the health care system. They come to us with a myriad of health problems. They make an appointment for a pill refill. However, while the nurse is taking the history, the woman reveals medical and social problems, all of which require treatment and/or referral.

Hospital-based programs have been a very important part of family planning in Illinois for a very long time. One of the first OEO grants for family planning was to the University of Chicago back in 1969. Their primary objective was outreach to hospital postpartum wards.

One of the first sites they chose was Michael Reese Hospital, which later became a title X program. They sent doctors and nurses there to counsel women about birth control. One of the nurses hired under that program was Mrs. Lamella Gales, who trained as a nurse at Provident Hospital.

One of the first patients Mrs. Gales encountered at Michael Reese was a 14-year-old girl named Brenda, who had just had her second baby. Mrs. Gales got Brenda into the family planning clinic and she was a successful contraceptor for 5 years, when she had twins at the age of 19. Brenda didn't give up, however. She struggled through high school and college. She now works in a daycare center and has put all of her four children through parochial school.

How do we know where Brenda is today? Just recently Brenda came back to the Michael Reese Clinic with her own daughter, who is now 14 years old. She brought her back to meet Mrs. Gales, who had made such an impact on her life. Unfortunately, because of funding problems, Mrs. Gales has just been laid off. But at the age of 77, she still works as a volunteer on the postpartum floor at Michael Reese Hospital.

At the University of Illinois clinic, 14 percent of our patients are 17 years old or younger. We have specialized teen services, as well as a bilingual health educator who has more than she can do to respond to requests from schools and community groups for presentations on all aspects of human sexuality, sexually transmitted diseases and contraception.

However, today I would like to emphasize the 72 percent of our patients who are not teenagers. They are adult women, 87 percent of whom are below the poverty level and who are planning their families. Forty percent of them are on public aid. However, many of the others are marginally employed as store clerks or in fast food restaurants. They are struggling to survive and fully understand the need to space and limit the size of their families. They can't afford $12 to $14 a cycle for birth control pills from their local pharmacy.

These are the majority of women who are dependent on title X for subsidized family planning services in order to keep up the struggle to make a better life for themselves and their children.

Thirty-five percent of the women who use the University of Illinois clinic are from two large Hispanic communities just to the south of the medical center. We have fully bilingual staff throughout the clinic.

Florentine has been coming to us for 5 years and speaks no English. She has had three children by choice in a milieu where seven or eight children are common. Her husband works, but earns $11,000 for their family of five. Florentine knows how important it is to space and limit the number of children and has brought five of her relatives and friends into the clinic for our bilingual education and services.

Also Tanya, who is now 27 years old, first started coming to the Illinois Masonic Family Planning Program 11 years ago when she already had two children and was on public aid. Even though she was a 16-year-old single mom, she was a successful contraceptor and finished high school and now works as a public aid caseworker.

Hospital-based clinics are not large, impersonal programs. Patients are very loyal and will ride public transportation just to get to the hospital that they identify with. Often they or their mothers were delivered at Cook County Hospital and they won't go anywhere else; or their family members have always gone to the University or Mount Sinai and they trust the staff there.

It is crucial that title X be reauthorized to enable us to continue these important and essential services.

Thank you.

Mr. **Waxman**. Thank you.

[The prepared statement of Ms. Waggoner follows:]

TESTIMONY OF

BARBARA WAGGONER, MPH
DIRECTOR, AMBULATORY WOMEN'S HEALTH CARE PROGRAMS
DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
UNIVERSITY OF ILLINOIS

Chairman Waxman and Committee Members:

I am here to talk to you about hospital-based Title X family planning programs in Illinois. I work for the University of Illinois at Chicago which has had a Title X funded program since 1980. In addition to ours, there are seven (7) hospital-based programs in Cook County. They have made a very important contribution to family planning in the State of Illinois.

During 1986, 56,353 low-income women received family planning services in the City of Chicago. Thirty-four percent (34%) of them were seen in Hospital-based clinics.

Three of the eight hospital-based programs are located in Regional Perinatal Centers which means that we provide tertiary prenatal care and delivery to women with high-risk pregnancies. Many of these women come from the 19 Chicago Community Areas which have been targeted by Governor Thompson's Infant Mortality Reduction Initiative.

In our continuing fight to lower Infant Mortality Rates, it is essential that women who have just had a high-risk pregnancy have access to education and subsidized family planning services.

In addition, the low-income women in the hospital-based programs tend to use the family planning clinic as their entry point into the health care system as a whole. They come to us with a myriad of health problems. They may make an appointment for a pill refill. However, while the nurse is taking the history, the woman reveals medical and social problems, all of which require treatment and/or referral.

Hospital-based programs have been a very important part of family planning in Illinois for a very long time. One of the first OEO grants for family planning was to the University of Chicago back in 1970. Their primary objective was outreach to hospital postpartum wards.

The Michael Reese Family Planning Program was started during that time by sending counselors and nurses to postpartum wards to counsel women about birth control. One such nurse from the beginning days of the Michael Reese Program was named Mrs. Lamella Gales, who trained as a nurse at Provident Hospital.

One of the first patients Mrs. Gales encountered at Michael Reese was a 14 year old girl named Brenda, who had just had her second baby. Mrs. Gales got Brenda into the family planning clinic and she was a successful contraceptor for five years, when she had twins at the age of 19. Brenda didn't give up, however. She struggled through high school, and college. She now works in a day-care center and has put all of her four children through parochial school.

How do we know where Brenda is today? Just recently, Brenda came back to the Michael Reese Clinic with her own daughter, who is now 14 years old. She brought her back to meet Mrs. Gales who had made such an impact on her life. Unfortunately, because of funding problems, Mrs. Gales has just been laid off. But, at the age of 77, she still works as a volunteer on the postpartum floor at Michael Reese Hospital.

At the University of Illinois clinic, 14% of our patients are 17 years old or younger. We have specialized teen services, as well as a bilingual health educator who has more than she can do to respond to requests from schools and community groups for presentations on all aspects of human sexuality, sexually transmitted diseases and contraception.

However, today, I would like to emphasize the 72% of our patients who are not teenagers. They are adult women, 87% of whom are below poverty level, and who are planning their families. Half of them are on Public Aid. However, many of the others are marginally employed as store clerks or in fast food restaurants. They are stuggling to survive and fully understand the need to space and limit the size of their families. These are the majority of women who are dependent on Title X for subsidized family planning in order to keep up the stuggle to make a better life for themselves and their children.

For example, Candy first came to the Cook County Family Planning Clinic in 1970, when she was 14 years old. She comes from a family who were on Public Aid. However, Candy was a successful contraceptor, finished high school and college before marrying and starting her family. Her second pregnancy was a tubal pregnancy. It was identified in the Family Planning Clinic and her surgery was at CCH. Candy completed her planned family with her second child and still comes to the Cook County Program.

Thirty-five percent of the women who use the University of Illinois clinic are from two large Hispanic communities just to the South of the Medical Center. We have fully bilingual staff throughout the clinic. Florentine has been coming to us for five years and speaks no English. She has had three children by choice in a milieu where 7 or 8 children are common. Her husband works, but earns $11,000 for their family of five. Florentine knows how important it is to space and limit the number of children and has brought five of her relatives and friends in to the clinic for our bilingual education and services.

Also, Tanya, who is now 27 years old. She first started coming to the Illinois Masonic Family Planning Program 11 years ago when she already had two children and was on Public Aid. Even though she was a 16 year old, single Mom, she was a successful contraceptor and finished high school and now works as a Public Aid caseworker.

Hospital-based clinics are not large impersonal programs. Patients are very loyal and will ride public transportation by several other providers just to get to the Hospital that they identify with. Often, they or their mothers were delivered at Cook County Hospital and they won't go anywhere else; or, their family members have always gone to the University or Mount Sinai and they trust the staff there.

It is crucial that Title X be reauthorized to enable us to continue these important and essential services.

Thank you.

Mr. **Waxman**. Dr. Nelson, let me start with you.

You are a physician, are you not?

Ms. **Nelson**. Yes, sir.

Mr. **Waxman**. You heard my discussion this morning with Dr. Windom regarding the administration's proposed regulations regarding family planning clinics.

Do you believe a physician should consult with patients about all options available to her? Do you feel that it is ethical for a physician to withhold information from a patient about treatment options?

Ms. **Nelson**. Absolutely the patient must be informed of all the options that are available to her.

Everytime I take a patient to surgery, I must tell her what the nonsurgical options are, as well as surgical. It is part of her right to be informed.

Mr. **Waxman**. In outlining options to women in the family planning clinic, do you advocate any particular option or do you have to make any of them available to people?

Ms. **Nelson**. You have to tell the patient what is available to her. You can't assume she knows what she has available. You have to tell her, just because you can't know what is in her mind. You have to give her each of the options so she can make an informed decision for herself.

The double standard here is very uncomfortable. We just had a recent law in California that said to protect women's fertility, before a hysterectomy can be performed, I must go through a two-page informed consent form. I must go through each of the options available to her to avoid surgery: medical treatment, myomectomies, all of these other things. But, on the other hand, I am getting a message from the administration that under other circumstances some things you can't even tell the patient what is available to her.

This double standard in different settings is intolerable.

Mr. **Waxman**. Not only do you have a conflict between the State law and what the administration would like to have as Federal law, but you have a conflict between what the administration would like you to do—not mention abortion as an option—and your professional ethical standards in giving the best judgment and guidance to the patient in order to have that patient exercise her options.

Ms. **Nelson**. It is actually withholding information from her. It is not a passive act; it is a very aggressive act, a very positive statement. By not providing her information, I am limiting her options.

That is unethical. As a physician, I just could not do that. You may ask why does a pregnant patient come to a family planning clinic? Why would she go there for her pregnancy testing? Why not just eliminate pregnancy testing in family planning clinics altogether and then you won't have that as a question? Strip that away, I am still left with the question of what devices to offer a patient who comes in.

Why has she missed her period? Does that mean I can't offer her a pregnancy test to find out whether I can give her something else?

You can't have the whole program without offering pregnancy testing and you can't offer pregnancy testing without telling a patient what each of her options is.

Mr. Waxman. Thank you.

Ms. Waggoner, sometimes people think—I certainly got the impression this morning—if it is a family planning clinic, all the staff do is talk about contraception, give some contraceptive prescription, perhaps counsel a woman to abstain from sex. But if it is a question of a woman's being pregnant, that is not the business of the family planning clinic any longer.

Is that an accurate picture of what is going on or do we have a whole range of services provided at the same setting where a woman would come in for family planning services?

Ms. Waggoner. I think you have heard over and over today that women—poor, low-income women—use title X services at almost any site, as their entry point into the health care system.

Mr. Waxman. It becomes a clinic for them to come in for any medical needs they have.

Ms. Waggoner. Absolutely. Very often it is either that or the emergency room, and when there are children they take them to the emergency room. Most women use their gynecologist—even women who aren't low-income tend to use the gynecologist as the starting point—because you go there for ongoing care.

I think the hospital-based systems are a little bit more this way because if patients are sick they tend to come to us, rather than the local Planned Parenthood, just because they already know they are not feeling well. So they feel they can get referred within the hospital system.

Mr. Waxman. Now, the contested regulations the administration is proposing, in addition to saying you can't even mention abortion, they want to have a complete separation of family planning activities and privately financed abortion services, even in a hospital.

Title X grantees under these regulations would not simply have to separate the funds for contraceptive services as opposed to abortion services, but provide separate buildings, personnel, stationery, everything.

How do you think this would affect most hospitals that now have a family planning clinic and also provide abortion services?

Ms. Waggoner. I hesitate to answer for more than my own, but I did go to each one of the hospital-based clinics in the city of Chicago and inquire, and in some cases, about half of the cases, the abortion services are in the same area and the regulations would definitely affect them.

In most cases, however, the department chairman responded by saying, I will allow my house staff to function within the limits of the law because we have a family planning clinic in one part of the hospital. You cannot say to another physician who is in a private relationship with their patient that they cannot speak of the various pregnancy options, or because they use the same secretary or the woman who walks in the front door obviously speaks to the same receptionist, that those services are incompatible. It is not even thinkable.

Mr. Waxman. If a hospital provides in one area a service for abortions and they are also getting Federal funds for family planning services and now they are going to have to choose between the two because of the proposed Federal regulations, which one will they choose to keep?

Ms. Waggoner. I can only speak for myself, but I would think they would give up the title X dollars because you cannot put those restrictions on all physicians within your hospital. It is just not something that you can do.

Also the abortion services often bring in more money than the family planning services do. Title X is not highly funded.

Again, I cannot speak for everyone, but as long as abortions are legal, title X really cannot compete over the rest of the medical system.

Mr. Waxman. Dr. Nelson, do you have something to add to that?

Ms. Nelson. Yes, I am part of a hospital-based system also. We have gone to a very aggressive antepartum detection for birth defects program. We have required alpha feta protein testing, amniocentesis, all of these things, and looked to abortion as an option for a patient, when she discovers her baby has a life-threatening or incompatible-with-life defect. If we could not offer that in our hospital, we would again face the same question.

I do believe that title X services would be the one that would leave, not the abortion services.

Mr. Waxman. So if there are not family planning services available, in a community like Ms. Jarman's, there may not be any available for any one in the community at all if the title X program closes up.

Is that right, Ms. Jarman?

Ms. Jarman. That is correct.

Mr. Waxman. There seems to be a lot of confusion about what is called nondirective pregnancy options counseling.

Could we have some description of how you do such counseling?

There seems to be a lot of confusion about pregnant women in family planning clinics and some assumptions that only nonpregnant women come in.

Can you explain the services that you provide, why some pregnant women do come in, what you think about Dr. Windom's suggestion that all pregnant women with health concerns be immediately sent elsewhere? How would that work in practice?

Ms. Jarman.

Ms. Jarman. I can start off just by saying it would work terribly.

It amazes me that someone can suggest that a woman come in for a pregnancy test and receive a pregnancy test and you say, yes, you are pregnant, or, no, you are not pregnant, and dismiss her. Even the medical implications of all of that aside, I think it is inhuman to treat anyone like that.

It is important to know—and I think you referred to this earlier—that there is a lot of information that goes to the patient at the time of that pregnancy testing that isn't directly related even to the options that she has to consider: nutrition information; if she is pregnant, information on the importance of not smoking; a range of medical care issues that must be addressed, if indeed, she decided to continue the pregnancy. In many communities it may be weeks and weeks before she even has an opportunity to get in to see an ob-gyn. So it seems to me it is critical that we must be able to discuss all of the options.

Also, if, indeed, she decides that she wants to terminate her pregnancy, again if she has not received adequate counseling at the time, she could again go weeks and weeks and weeks into the pregnancy before she has had an opportunity to fully explore this possibility.

Mr. **Waxman**. It strikes me that if a clinic is going to be so nervous about talking to a woman about the possibility of an abortion, should that woman be thinking about an abortion and realize she is not going to get any counseling from them about it, she will go home and, if she is unhappy about being pregnant, maybe sign up for an abortion without having talked it through with someone, when maybe through counseling she would have decided not to have an abortion. But because of the sort of bureaucratic maze that they want to set up for fear that women will know their options and think them through and decide for themselves what they want to do, they may well be pushing people into more abortions.

I certainly think that is the case. I never could understand this: why the people who are against abortion fight against contraception. If you don't have programs for family planning to avoid pregnancy and you have more unwanted pregnancies, there are clearly going to be more abortions.

That always befuddled me, that the anti-abortion forces look at this whole thing from behind blinders that keep them from seeing that reality.

Maybe, Mr. Klausmeier or Ms. Waggoner, either one of you, can you tell me more about how you discuss the option of abortion. The law provides that you have to give nondirective pregnancy option counseling, including information about abortion. These are the guidelines. Suddenly the administration has switched it around and said, in effect, that you can't give even nondirective information about abortion.

How would it be handled if you are giving nondirective abortion counseling?

Mr. **Klausmeier**. I think the point was made this morning that this is a reversal of what the title X regulations have required; that is, that we give each pregnant woman all three choices, whether she wants to have a child and be referred for prenatal care, the option of adoption or abortion. The point has also been made that we are often advocates for pregnant women who need help in getting into the health care delivery system for delivery services and prenatal care.

It is not unusual for us at Family Health Services to be assisting a woman for a month or two, especially low income women with this entry process, especially if it is the first child. We also have a problem getting these low income women obstetrical care. That is not only a problem in our community, but it is a problem across the country.

What has not been said yet today is that we spend a lot of time doing that. I think that fits title X. I think it is very important, and I also think it is very important that we provide all the options in an unbiased fashion; that we not weigh either one of the options. If a woman chooses to have an abortion, that is a decision between her and her doctor. And it is a legal option in this country.

Ms. **Waggoner**. Can I add something? I think we are doing our patients a disservice. They may be poor, but they are not blank slates that walk into us and whatever we say first is what they are going to do. When you say the word, "abortion," to them, they are going to make their own decisions because they are thinking human beings. It isn't because we give that option as one of the several available to them that they are automatically going to make that decision.

Mr. Waxman. The groups opposed to family planning believe that what is happening is that the people are being encouraged, if they are not happy about being pregnant, encouraged to have an abortion.

Ms. Waggoner. I can assure you that we give them information. We do not encourage them to use one method or another method. We provide them with information. Our whole reason for being there is to educate that consumer and having her participate in her own care and her own decisionmaking, to have her go back to school to stay in school, to get a job, to get off public aid.

She needs to be able to make her own decisions. We try to get her to the point where she can do that.

Mr. Waxman. Let me change to another question that is very important. That is the AIDS issue. In your clinics, I am sure you have occasions for the issue of AIDS to be brought up because AIDS is a sexually transmitted disease. Do you support counseling and testing in the family planning clinics for AIDS, and do you believe that a Federal confidentiality and nondiscrimination policy would assist in this effort?

Anybody want to take that on? Mr. Klausmeier.

Mr. Klausmeier. I think a Federal initiative would be helpful. I believe philosophically that HIV testing and counseling should be available in family planning programs. There is then the question of the financing of such a venture. HIV testing and counseling would be one more thing being added to the title X list of services.

I believe it should be added and we have begun in our own clinic sites to offer HIV testing and counseling on a confidential basis. It is very important if title X is going to mandate AIDS testing and counseling on a national basis that there be forthcoming an appropriation to allow the clinic to do that.

I think family planning clinics are well-equipped medically to handle the HIV testing and couseling, but they would need financial support as well.

Mr. Waxman. If you had the financial support, do you think the Federal Government ought to mandate that every woman that comes into a family planning clinic be tested and counseled?

Mr. Klausmeier. Absolutely not. We believe in voluntary confidential testing for HIV infections.

Mr. Waxman. Why do you give them the option?

Mr. Klausmeier. Why do we give them the option of whether they want to be tested or not?

Mr. Waxman. Right.

Mr. Klausmeier. I think medicine in this country is based on informed consent and voluntary participation. If we were to move to a practice of medicine that was forced medicine, then I think we would change what the medical system is about and we would change it in a negative way. I also think in this case, if it were changed specifically for this issue, that it would drive the disease underground and make it more difficult for generations to come to fight this battle against AIDS.

Mr. **Waxman**. Dr. Nelson.

Ms. **Nelson**. In the short run and I think long run also, a mandatory policy would exactly turn around what we want to have happen. People would avoid coming to family planning clinics as soon as they knew the testing was required. The next step after mandatory testing is going to be contract tracing and you are going to have this whole array of very invasive procedures into the patients' lives.

I think they would walk with their feet and stay away from the clinics.

Mr. **Waxman**. Especially if that information is given out, if confidentiality is not protected, or if it does get out some way or other, people will lose their jobs and be discriminated against simply because they have a positive test. And I understand there is even discrimination against people who ask for the test to be taken, because some insurers are saying if you ask that you be tested for AIDS, there must have been some reason you were worried about it, and therefore they don't want to insure you.

It seems all those become obstacles for people to even come in and be tested. We want to remove the obstacles if we want the test information to get to the individual so counseling can encourage them to change the kind of behavior that would spread the disease to others.

Ms. **Nelson**. The second half of that is if a patient were to get a negative result back, he or she should not be falsely reassured. There is a long latency time and people should—everyone should be practicing safer sex. We should be including this and I am sure we all are, as part of our education efforts with patients.

Please don't think just because your partner has a negative test result today, you oughtn't be using safe sex practices. The false assurance is just as important as the invasion and the ethical issues also.

Mr. **Waxman**. I want to thank you. You have been a very good panel. I appreciate your being with us. Your information will be very helpful.

Appearing on our last panel is Dr. Duane Alexander, Director of the National Institute of Child Health and Human Development, which is part of the National Institutes of Health. NICHD is the primary institute responsible for carrying out federally supported research on issues related to contraceptive technology and development.

Dr. Alexander is here today to discuss our national efforts in this field. We have already received your prepared statement for today's hearing. Dr. Alexander, we will have that as part of the record. We would like to ask you to summarize and make your oral presentation in 5 minutes.

STATEMENT OF DUANE ALEXANDER, DIRECTOR, NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT, NATIONAL INSTITUTES OF HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. **Alexander**. Thank you, Mr. Chairman.

Mr. Chairman and members of the subcommittee, I am Dr. Duane Alexander, Director of the National Institute of Child Health and Human Development [NICHD], of the National Institutes of Health. I am here to provide you with information on the contraceptive development activities of the NICHD.

Since its establishment in 1962, the NICHD has put emphasis on programs in the reproductive sciences. This research has provided a broad science base in the fields of human fertility, reproductive biology and infertility.

In 1968, the President's health message to Congress directed that the center for Population Research be established within the NICHD. The Center is responsible for grants and contracts in population research and is the focal point in the Federal Government for population research and training.

The goals of the Center are the advancement of fundamental knowledge required for maintenance of the reproductive health of men and women; the identification and development of new leads from basic research for safe, effective and acceptable methods of fertility regulation for use by men and women; and the alleviation of human infertility.

Mr. Chairman, contraceptive development is a major part of NICHD's responsibility for the enhancement of health by improving the ability of couples to regulate the number and spacing of their children, and by assuring the safety and protective effects of current and new contraceptive methods, including their role in preventing sexually transmitted diseases. In view of current social and health problems, the NICHD has undertaken a special initiative to support research leading to the development of new methods of contraception and the improved use of existing methods.

The objectives of this contraceptive development initiative, which was approved by the NICHD National Advisory Council, are: one, the development of an array of contraceptive methods that are safe, effective, reversible, inexpensive, easy to administer and acceptable to various population groups; and, two, the more widespread and effective use of methods that are currently available in the United States or that could be made available with adequate assurances of safety.

The current predicament of older women of childbearing age in the United States provides an example of the need for improvements in the regulation of fertility. Most of these women have had all the children they want and therefore desire totally effective contraceptive. Yet, all intrauterine devices, with one exception, have been removed from sale in the United States; many physicians recommend against the indefinitely extended use of the contraceptive pill; and the remaining methods have higher failure rates than the pill or the IUD.

For this reason, most of these women, or their husbands, become sterilized. Yet, for many, sterilization is not ideal. It virtually closes options for future childbearing, and many find this objectionable. For such couples a highly effective, completely safe and reversible method of contraception would be ideal, but it does not yet exist.

Among other groups, women's ability to manage their own fertility is far from perfect. Women report that more than half of all pregnancies are unintended, that is, either unwanted or ill-timed. This means that of the 6 million pregnancies occurring annually, more than 3 million are unplanned. Many unplanned pregnancies result in births to unmarried women, which now account for one in five births.

The high incidence of unplanned childbearing has adverse effects on the health of mothers and children and on the ability of families to maintain economic independence. The problems associated with unplanned childbearing are most severe among very young women and among those living in poverty, although the impact is perceptible at all socio-economic levels.

Health is another concern directly related to the imperfect regulation of fertility.

Recent surveys show a close relationship between the health of the baby and whether or not the mother intended to become pregnant. Not surprisingly, women with unintended pregnancies report that they first obtain prenatal care later in pregnancy than those who intended to become pregnant. Furthermore, among the births resulting from unintended pregnancies in the United States during 1979 to 1982, the prevalence of low birthweight—below 5 pounds, 9 ounces—was significantly greater than among planned births.

Thus, efforts to help couples avoid unintended pregnancies will complement and enhance the Institute's efforts to reduce the incidence of low birth weight and to improve the health of mothers and children.

As you know, Mr. Chairman, another very serious health problem that has arisen in this decade is the AIDS epidemic. Efforts at preventing its spread by sexual transmission must focus on influencing sexual and contraceptive behavior. Much of the behavioral research in the initiative will be relevant to AIDS prevention as well as to the ability of individuals to manage their fertility.

In addition, NICHD supported scientists are conducting laboratory tests of condoms to determine their effectiveness in preventing the transmission of AIDS and are investigating and attempting to improve the protective effects of spermicides.

Of the 47 million sexually active women of reproductive age in the United States, about 95 percent have used some form of contraception. However, there is a wide gap between their fertility aspirations and outcomes, much of it due to ineffective and episodic contraception. In addition, there is fear and confusion in the minds of many individuals about the safety of various contraceptive methods, which impedes their effective use. These issues can be addressed by much of the research in the initiative.

While the Institute's Contraceptive Development Branch has been the major focus for the development of new contraceptives, the remaining three branches of the Center for Population Research also actively support the Contraceptive Development Initiative.

Specifically, the Center's Reproductive Sciences Branch supports basic biomedical research in mammalian reproduction, including in humans, to discover possibilities for modifying reproductive processes that may lead to the development of new methods of contraception.

The Contraceptive Evaluation Branch studies the safety and effectiveness of methods that have been used in the United States and other countries in order to determine whether they may gain more widespread use. And the Demographic and Behavioral Sciences Branch supports research on behavioral aspects of contraceptive use to determine why many couples do not use contraception when pregnancy is not wanted and to identify the characteristics of methods that may make them more acceptable to various population groups.

In fiscal year 1987, the Institute expended $17.4 million to implement its contraceptive development initiative. The Institute anticipates spending approximately $20 million for the initiative in fiscal year 1988, and the President's budget for fiscal year 1989 calls for an expenditure of $22.5 million.

New contraceptive drugs and devices which the NICHD is currently developing include:

CAPRONOR IMPLANT

One of the more promising potential new contraceptives is Capronor, a biodegradable implant for women. Capronor, a thin tube that is inserted under the skin, releases small, steady amounts of a contraceptive drug. The device is designed to be absorbed over time and thus does not need surgical removal. In a current study, no pregnancies have occurred among a group of volunteers, some of whom have been in the study for almost a year.

LONG-ACTING INJECTABLES

While the NICHD is not presently conducting clinical studies with long-acting progestins, the World Health Organization, WHO, is doing so with compounds that were developed under a joint NIH/WHO program. Preliminary clinical data with one of the compounds, levonorgestrel butanoate, are encouraging in that a single administration of a rather low drug dose can provide effective contraceptive for 2 to 3 months.

LHRH ANALOG

Toxicological assessments of new chemical copies of luteinizing hormone-releasing hormone, LHRH, a hormone produced in the brain that regulates reproductive processes in both men and women, are being carried out and followed by clinical trials, among men and women.

TRANSDERMAL PATCHES

Administration of drugs through the skin has several potential advantages, including utilization of natural steroids, greater opportunity for programmed administration of synthetic steroids, and ready reversibility. Some of the skin patches are in the final stages of development and early clinical testing.

IMPROVED IUD CONTRACEPTION

Clinical trials are proposed to determine whether a significant portion of pelvic inflammatory disease that is caused by intrauterine devices, IUDs, can be prevented by antibiotic prophylaxis at the time of insertion. In addition, a clinical trial is proposed to evaluate several new changes in IUD design.

IMMUNOCONTRACEPTION

This is the prevention of fertility by immunologic methods. Recent studies have shown the existence of antigens on male or female gametes or reproductive hormones that can be used to induce immune reactions, causing markedly reduced fertility or even sterility.

INHIBIN

NICHD supported scientists have isolated and characterized a protein called inhibin, which is produced in the gonads and appears to block a hormonal step necessary for the development of sperm and egg cells. We are obtaining large quantities of this substance to test its potential for fertility regulation in different animal models.

IMPROVED CONDOMS AND SPERMICIDES

Barrier contraceptives today play a role in preventing the transmission of the AIDS virus and other sexually transmitted diseases, as well as preventing pregnancy. The Institute is currently supporting studies designed to determine the effectiveness of condoms alone and in conjunction with spermicides in preventing the spread of the AIDS virus. We are also working to develop improved condoms that will be more effective for both purposes.

Mr. Chairman, the NICHD is actively pursuing its mandate to improve drugs and devices and their utilization which will enable the voluntary regulation of fertility and reduce the proportion of unplanned pregnancies.

This concludes my testimony. I shall be pleased to answer any questions that you or the members of the subcommittee may have.

Mr. WAXMAN. Thank you very much, doctor.

Your point about unwanted, unintended pregnancies was interesting. We had a discussion earlier today in this hearing about whether a teenager who is pregnant or any woman who is pregnant who is married, whether that is a problem. The witness seemed to think the only problem was unmarried women who were pregnant. But the reality is that if a child is not wanted, if a pregnancy is not desired, some women, even if they are married, legally—and it may only be a legal status and nothing more—may be without the prenatal care for that child.

We have in this country a scandalously high infant mortality rate, which means that many women are not getting prenatal care or not bothering to take care of themselves when they are pregnant because they don't desire that child.

One of the results is a high incidence of death for babies and but also a high incidence of handicapping conditions for children who are born without that loving care indicating they are wanted from the very beginning of the pregnancy.

Mr. **Alexander**. You are quite correct, Mr. Chairman. The incidence of out-of-wedlock pregnancy and births in this country is increasing in terms of actual total numbers. More of the unwanted pregnancies occur among married women than unmarried.

Mr. **Waxman**. I was interested in the comments by some of the people who run the clinics. Seventy percent, in one case, were adult women and only a smaller percentage is teenagers. You would think, with all the talk about the family planning clinics, that they are only designed for teenage girls.

Those are important clients, but they are not the only ones who want to have and should have available to them these contraceptive services, especially if they can't afford to see a private doctor.

Your job is to do research on new contraceptive technologies, and we have a problem in this country because of the liability situation. Some contraceptives are just not even available any longer. Some are questionable as to whether they are safe or not.

I am sure you are aware of the contraceptive research going on in the private sector. Can you give us some idea about what has been happening in terms of funding for contraceptive research in the private and public sectors over the last 5 years?

Mr. **Alexander**. Yes, Mr. Chairman.

As part of its responsibility, our Institute prepares inventories of private agency population research and of Federal population research. The trends in these analyses indicate that in the private sector, excluding private industry, there is less and less investment in contraceptive development research. From its peak year in 1981, when the investment was $4.4 million, the 1985 figure, which is the most recent we have, indicates an investment of about $2.5 million from the private sector.

Again, this does not include private industry. I do not have those figures available.

In the Federal sector, our efforts have increased. Our efforts in the Contraceptive Development Branch at NICHD have gone from an investment of $5 million in 1984 to an investment of $8.8 million in fiscal year 1987. We anticipate approximately $9.5 million in fiscal year 1988.

Mr. **Waxman**. What looks promising in the private sector in terms of this research?

Mr. **Alexander**. Norplant, which is a comparable compound to Capronor and looks very promising. That has been developed by the Population Council. I mentioned that earlier.

Another promising advance looks like the vaginal ring that is designed to be worn for up to 3 months in a nursing mother or up to a year in a nonnursing mother and can provide contraceptive efficacy for that period of time.

Other approaches are similar to things that are being worked on by NICHD, that is, long-acting injectables, transdermals and modified IUDs.

Mr. **Waxman**. Is there much work being done on male contraceptives or only on female contraceptives?

Mr. **Alexander**. Male contraceptives are being approached also. Again, primarily by the Federal sector, not so much on the private side.

As I indicated, we are working on improvements.

Mr. **Waxman**. They don't see a profit potential.

Mr. **Alexander**. They see great difficulties and lots of development time required because of the increased difficulty in producing a male contraceptive. We are working with the LHRH analogs, chemical copies but modified copies of a chemical produced in the brain that can turn off the signal to produce sperm or ova, or to induce ovulation.

One of the problems with these is that, in addition to suppressing spermatogenesis, they suppress libido. The male injections would have to be given simultaneously.

We also are working with long-acting compounds of testosterone that would be effective with one injection for 8 to 12 weeks. In larger doses it suppresses spermatogenesis. You have such a large amount of sperm production to suppress in the male. Though you may reduce the count considerably, you have to reduce it probably to zero to be 100 percent effective.

Mr. **Waxman**. Earlier I asked Dr. Windom if HHS has ever supported any research on RU486 as an abortifacient. He made it clear that it has not. I understand that NICHD is doing some research on this drug.

Would you please explain exactly what research is going on at NIH.

Mr. **Alexander**. Dr. Windom is absolutely correct. In conjunction with the department policy and directives, we have not supported research on the use of RU486 as an abortifacient. There are a number of other applications of this drug. First, above and beyond its contraceptive use, its antiprogesterone action makes it appealing in a number of other uses.

For example, there are breast tumors, cancer, that is responsive to estrogen and others responsive to progesterone. One of the new and promising therapies for estrogen-receptive breast tumors is the use of Tomoxifin, which blocks estrogen. RU486 projects progesterone so it could be effective as an anticancer agent for breast tumors. Its use is also being explored there in treatment of Cushing syndrome and adrenocortical excess.

In the reproductive area, which is the main interest here, we are looking at it as a potential contraceptive agent. And here the distinction is in really the time of administration. The areas which we are exploring would be those in which the drug would be administered prior to the time of pregnancy.

One possible use that is being looked at is the administration of a very small dose of this throughout the menstrual cycle so that there is no receptive endometrium prepared for implantation. Another would be the use of one or two doses of RU486 at some point in the cycle in order to remove the endometrium all at once.

Those are not abortifacient uses by accepted definitions. They are contraceptive uses, and this is basically what is being explored. These are studies in early stages, looking primarily at the physiology of progesterone and its action and how this new compound works. We are trying to learn as much as we can about its potential uses as a contraceptive, not as an abortifacient.

Mr. **Waxman**. Thank you very much for your testimony to us. That completes the agenda for this subcommittee hearing. We therefore stand adjourned.

[Whereupon, at 3:05 p.m., the hearing was adjourned.]

[The following statements and letter were submitted for the record:]

STATEMENT OF

PLANNED PARENTHOOD FEDERATION OF AMERICA, INC.

INTRODUCTION

I am Faye Wattleton, President of the Planned Parenthood Federation of America (PPFA). On behalf of the more than 30,000 volunteers and staff who run our 181 affiliates in 46 states and the District of Columbia, the 250,000 individuals who contribute to our organization, and most importantly, the more than 4 million women and men who are served by our affiliates each year, I want to thank the subcommittee for holding this hearing. I appreciate the opportunity to submit our views on the state of our nation's efforts to reduce the incidence of unintended pregnancy, particularly among the poor and the young.

In 1970, Congress passed and President Richard Nixon signed into law the Family Planning Services and Population Research Act -- now Title X of the Public Health Services Act. The United States government clearly and unequivocally committed itself to enabling all individuals to freely decide the number and the spacing of their children.

From those earliest days of its history, Title X has enjoyed bipartisan support. Democrats and Republicans in both houses of Congress embraced the concept -- and supported the program -- of using government resources to make voluntary family planning available as a tool to enhance the health and welfare of mothers and children, through the prevention of unintended pregnancy.

Members on both sides of the aisle, and on both sides of the abortion question, also embraced federal support for family planning as the single, most direct means available to reduce the need for abortion among women in this country. (One of the early, vocal supporters of the program was a

Republican Congressman from Houston, now Vice-President George Bush.) Given this history, it has been hard to comprehend the hostility of the current administration to the Title X program.

OVERVIEW OF SERVICES PROVIDED BY THE TITLE X PROGRAM

Title X is the only program through which Congress can affect and monitor the extent to which family planning services are provided around the country; it provides half of all federal funds for services; it serves as the program base from which other sources of support -- state and local -- can be obtained.

Title X authorizes project grants to both public and private nonprofit organizations to provide family planning services (including natural family planning and infertility services), with priority given to low-income persons. The services program is complemented by a training program for clinic personnel, information and education activities and strict evaluation requirements to ensure program accountability. Section 1008 prohibits the use of Title X funds for abortion.

Title X is the nation's principal vehicle for preventing unintended adolescent pregnancies. Of the approximately 5 million women served in organized programs in 1986, approximately one-third were young women in their teens. According to the Department of Health and Human Services (DHHS), about 80 percent of all family planning services provided to teenagers in specialized clinics are in programs supported by Title X.

It is demonstrable that dollars spent for family planning save a great many more dollars in the direct and indirect costs associated with unintended pregnancies. But since Title X services are not limited to the poorest of the poor, nor to women on welfare, Title X also plays an important role in helping marginal-income individuals and families remain independent financially.

This is particularly important where teenagers are involved. More often than not, teenagers who become pregnant have few marketable skills, too little education and few resources for adequate support. Moreover, according to a study recently published by the Center for Population Options, the United States government spent $18 billion in 1986 for families that were begun when the mother was a teenager. This figure is conservative because - while it includes direct and administrative costs for Aid to Families with Dependent Children, food stamps and Medicaid - it does not take into account associated costs such as social services, public housing and child care. The report also estimated that babies born to teenagers in 1986 alone would cost the U.S. $5.5 billion over the next twenty years.

Title X is important to the health and well-being of nearly every family in another way which attracts less public attention. The program currently authorizes research in the reproductive sciences, social and behavioral studies, contraceptive development and contraceptive evaluation. The National Institute of Child Health and Human Development (NICHD) administers all these areas of research, which together are presently funded at approximately $109 million, and is the leading entity worldwide performing this type of research. Yet this area of study has a low priority at the National Institute of Health (NIH).

It is well recognized by now that virtually all contraceptive methods still in use have some drawbacks. As a result, contraceptive use -- while nearly universal in our society -- is often both imperfect because of existing methods, and because human beings, too, are imperfect. The inadequacy of available contraceptive methods is reflected in the fact that more than half of the approximately six million pregnancies that occur each year are unintended.

While we wait for better contraceptive methods and choices to emerge, there are 36 million American women faced with the everyday problem of how to prevent getting pregnant unintentionally. As I mentioned earlier, 5 million women rely on the subsidized family planning program to obtain services. While services to teenagers receive a great deal of attention it should be emphasized that two-thirds of patients in this program are adult women. In the early years of the program, many came to the clinics only after they already had all the children they wanted (or more). Today the typical patient does not yet have children. Sixty-nine percent are white, and eight in 10 have incomes below 150 percent of the official poverty level.

The majority of the teenagers served are 18 and 19 year-olds. Many teenagers delay seeking contraceptive help for a year or more after initiating sexual activity. Their first contact with a family planning clinic often occurs when they already are -- or think that they are -- pregnant. A major reason for the delay in seeking contraceptive assistance is fear that their sexual activity will become known to their parents.

Agencies that provide Title X services are as varied as the individuals and families they serve. Some 2,500 separate agencies operate clinics at over 4500 service sites in virtually every county in the country. Most Title X funds go to state or local health departments: forty percent of the patients are served by state and local health departments; Planned Parenthood affiliates serve 27 percent of the national caseload; 13 percent by hospital-based programs and the remainder (20 percent) by a variety of other agencies such as HMO's, neighborhood health centers, and free clinics.

Approximately $136.6 million was appropriated in FY 1988 for Title X family planning services, a $6 million dollar cut from the year before and nearly $30 million less that the amount appropriated in FY 1981. The bulk of that money has been or will be awarded to health departments, hospitals and the variety of county agencies just mentioned. Planned Parenthood affiliates received a total of about $30 million, or 20 percent.

I want to stress that Planned Parenthood is a federation of autonomous, local nonprofit agencies which operate with boards and staff from the communities they serve, within federal mandates and guidelines. Since Title X project grants are made only for direct family planning services, each Planned Parenthood affiliate must apply to the government on its own if it wishes to receive Title X support. Grant decisions are made by the DHHS regional offices based on applications from state and local health departments and various private nonprofit agencies. These applications in turn are based on a determination, at the community level, of which agency or combination of agencies is best suited to provide the needed services efficiently and effectively. In most instances, therefore, receipt by Planned Parenthood affiliates of federal funds is conditioned upon community-based decisions.

Title X-funded family planning clinics provide a variety of health care services and information for men and women. For many women, these clinics are their primary source of health care. Teenagers often enter the adult health care system through a Title X clinic. The contraceptive services funded by the Title X comprise a much broader range than most people realize, including education on reproductive health systems and all of the medically acceptable methods of birth control; contraceptive supplies with appropriate instruction; a complete health screening assessment; and laboratory tests that screen for sexually transmitted diseases, cervical and breast cancer, anemia, hypertension, kidney dysfunction and diabetes. Some family planning clinics also provide the additional services of prenatal care, infertility diagnosis and treatment and sterilization. Counseling is available for all patients, as is instruction pertaining to breast self-examination, pregnancy, human sexuality and nutrition.

The effectiveness of family planning services has been well established. Studies show that during the first decade of the Title X program 5.4 million pregnancies were averted, 2.3 million abortions were averted, and 2.5 million miscarriages were averted. The federal family planning program served 32.3 million patients (in patient years) during this time. Clearly, in socio-economic terms, Title X is cost-effective.

The need for federally-subsidized family planning services has only increased since the program was enacted in 1970. Between 1970 and 1981, the number of low-income women who were at risk of unintended pregnancy rose by about 30 percent, to 9.5 million. This is a direct reflection of the increase in the proportion of women who are poor. Only slightly more than half were able to obtain services. The subsidized family planning program removes the financial barrier that for many is the primary obstacle to receiving needed care. In 1985, 71.4 percent of new patients at Planned Parenthood clinics chose oral contraceptives, a higher proportion than any year since 1976. The average first-year private sector cost of using the pill, is $172. Not surprisingly, women of limited means often seek inexpensive, less reliable contraception or use none at all. Far from having reached a time when the need for services has been met, the demand today is even greater. As a result of an inability to obtain services, contraceptive failure, or a simple lack of understanding concerning pregnancy (especially among teenagers), half of all pregnancies are unintended and half of those end in abortion -- a clear indicator of the remaining problem for all women, with the greatest impact being felt by the poor and the young.

While the states and other federal programs (Medicaid, Maternal and Child Health and Social Services Block Grants) contribute financially to the national family planning efforts, the categorical, federal Title X program establishes the structure that is necessary for the program's high quality and effectiveness. Under Title X, national medical standards have been developed, there are informed consent protections for the patients, and oversight at the federal level ensures accountability for federal dollars. The growing support demonstrated by most states for family planning programs stems from the philosophical and programmatic direction provided by Title X. It is, therefore, imperative that the federal government which supports family planning as a basic public health service continue to provide clear policy direction by maintaining the integrity of Title X.

THE PROGRAM AND ITS POLITICS - A HISTORY OF HARASSMENT

Since Title X was reauthorized under the Omnibus Budget Reconciliation Act of 1981, the program has been intensely scrutinized, subjected to political harassment and administrative confusion. Thanks to the efforts of the program's congressional supporters, and to the integrity of the program itself, Title X has withstood this array of assaults. But open attacks on Title X that have been on going since 1981 should end.

The first such attack came in President Reagan's 1981 budget request to Congress. He proposed that year, and every year since, to eliminate the categorical family planning program, in favor of a primary care block grant to fund family planning along with family primary health care, migrant health, rodent control, STD, and black lung services. There would no longer have been a specific mandate to fund family planning services at any levels. In contrast, the administration's FY 1988 and FY 1989 budget request took a slightly different tack, placing family planning services alone in a block grant to the states. The proposal would eliminate federal standards on informed consent, confidentiality, and the types of services to be offered.

The budgetary attacks were followed in 1982 by the ill-fated parental notification regulations and the contemplated DHHS guidelines that essentially would have disqualified any agency that provides abortion from receiving Title X funds for family planning services. The DHHS effort to require federally funded family planning clinics to notify parents if their minor daughters sought prescriptive contraceptives drew a storm of protest from nearly 100 national organizations. Subsequently, DHHS announced the promulgation of these regulations. The federal courts barred their implementation and struck them down on grounds that they were inconsistent with both the letter and the spirit of the Title X statute, and thus contradictory to the will of Congress.

The courts have also taken stands against parental consent requirements, most recently in a 1984 case involving Utah's state department of health. In that case, Planned Parenthood of Utah and Park City Community Clinic were suddenly defunded in favor of the state health department which was planning to impose a recently-passed parental consent requirement for family planning services. Federal District Court Judge David K. Winder ruled that this was in direct conflict with the requirements of Title X and the state was deemed ineligible for these funds as long as it defied federal law. Most of the funds have now been redirected to those Utah providers offering services in compliance with Title X, namely, Planned Parenthood of Utah and Park City Community Clinic.

Then in 1983 came the sudden transfer of the Office for Family Planning to be administered by the Deputy Assistant Secretary for Population Affairs, in this case, a hostile political appointee. Although we support the position of DASPA for overall policy coordination with other DHHS programs complementing Title X (services under Medicaid, maternal and child health, social services, research at the National Institute of Child Health and Human Development, evaluation at the Centers for Disease Control and the Food and Drug Administration), we are concerned that Title X has been isolated from the other primary care and maternal and child health programs in the Health Resources and Services Administration. Despite congressional mandates to the contrary, the program continues to be administered by the DASPA. Related to the transfer of the Office for Family Planning is the fact that it has made it more convenient for DHHS to view Title X through the lens of the Adolescent Family Life Act (AFLA), which is being run from the same office. These two programs have entirely different goals, legislative histories, target population and service delivery systems. The Adolescent Family Life Act was ruled unconstitutional by a federal district court, and is currently before the Supreme Court because it fosters an excessive entanglement between government and religion.

In addition, we see a serious deficiency at DHHS in collecting and analyzing national program data. After terminating its long-standing contract with the Alan Guttmacher Institute in 1983, DHHS stated that it would conduct these activities itself. This has not happened and we urge the committee to ensure that DHHS follows through on this commitment, since program accountability is crucial to the program's success and future direction.

In 1986, under Deputy Assistant Secretary for Population Affairs Ann Gasper, the tenor of administration attacks on the Title X program increased dramatically. Mrs. Gasper subjected the Title X program to an unprecedented series of actions designed to do by administrative fiat what Congress has repeatedly refused to do through legislation.

In the summer of 1986, at Mrs. Gasper's instigation, DHHS Secretary Bowen announced plans to change the Title X Guidelines to make it optional for Title X grantees to provide pregnancy options counseling and referral to women facing an unintended pregnancy. This attempt to change the program administratively followed two unsuccessful legislative attempts to disallow counseling and referrals for abortions in Title X programs, and resulted in a directive from the Congress (in the report accommpanying the FY 1987 continuing resolution) prohibiting the administration from making changes in the Title X program.

Stymied by these defeats, Gasper - without clearance from her superiors - issued a program instruction in January 1987 ordering the regional administrators of the Title X program to defund Planned Parenthood affiliates and other organizations that "promote abortion." Her order was promptly rescinded and she was reprimanded and later fired.

A short time later, Nabers Cabaniss was appointed to run the program. On September 1, 1987, DHHS formally proposed sweeping regulatory changes in the Title X program which included fundamental redefinition of the term family planning. The primary purpose of the new regulations was, of course, to wipe out current DHHS guidelines which require non-directive counseling on all options for managing a problem pregnancy, and referral for abortion upon request. DHHS moved to promulgate these regulations in final form on February 2, 1988, despite the opposition of 36 state governments, 78 national organizations (including every major national medical association) and the deans of all 25 schools of public health in the country.

To date, the regulations have been struck down by federal district courts in Denver, New York, and Boston, with judges finding them to be both illegal and unconstitutional. Judge D.J. Skinner of the U.S. District Court of Masschusetts in Boston said, "In its attempt to implement a health care policy which promotes childbirth, the defendant has devised a system which rests in large part on keeping Title X clients in ignorance."

Legally blocked from implementing these inappropriate regulations for service providers, the administration has now served notice that it will attempt to attach new and inappropriate conditions to funds that provide training for nurse practitioners who serve Title X patients. That seems certain to embroil the program in yet another set of lawsuits.

SUMMARY AND RECOMMENDATIONS

In 1981, part of the price to pay for continuing family planning (as well as most other domestic programs) was to accept a drastic cut in appropriations. This year's appropriation of $136.6 million for services - a $6 million reduction from the year before - is still $30 million below FY 1981's level, not adjusting for inflation. Accounting for inflationary increases alone, since 1981 the current level of Title X funding should be approximately $210 million. As a result, family planning clinics have not only been fending off all the political attacks on the program's philosophy, but have been struggling under severely strained budgets. DHHS estimates that as many as 1,000 clinic sites have closed since 1982 for lack of funding. Numerous special projects have been discontinued, including male involvement and community education, among many others. In order to preserve the core of the program -- medical contraceptive services -- clinics have had to diminish their information and education activities. This has detrimental implications not only for teenagers, but adult women in light of the extent of public misinformation that exists about current contraceptive methods. It will certainly guarantee a continuation of the high level of unintended pregnancies in this country.

Title X is the only health program which has not, in monetary terms, recovered from the budget cuts of 1981. And yet the need for contraceptive services and information continues to grow. Planned Parenthood supports H.R. 3769, the legislation currently being considered by the subcommittee as an important first step in restoring adequate funding for the federal family planning program. Given the current budget deficit, we realize that the restoration of funding levels adequate to meet the need that exists will not happen overnight.

However, it is vital that continuing efforts be made to fund Title X at levels ensuring the continuation of services now being provided, with substantial progress made towards an expansion of services to the millions of women and teenagers in need who are currently not being served.

H.R. 3769 reauthorizes the information and education component of Title X, and places increased emphasis on the provision of materials and activities that will assist persons in making responsible choices concerning sexuality, pregnancy, and parenthood. In view of the increasing difficulty that many communities have had in maintaining their outreach and educational programs, Planned Parenthood endorses this effort.

In spite of the universal interest in better contraception, federal support for development of new or improved methods, as well as for the evaluation of the safety and effectiveness of current ones, has actually declined since FY 1981. Five years ago, the Office of Technology Assessment (OTA) recommended that an additional $20 million annually be provided in federal funding for contraceptive technology, noting that available research opportunities are only waiting to be exploited. This is not a field for which a single, even a massive injection of funds would be adequate. Rather, steady and reliable funding at a modestly higher amount could bring some of these leads to fruition. For example, with continued funding at currently budgeted levels, 10 new products should be ready for registration within 1-3 years.

We need new safe and effective methods of contraception, and we need to reassure ourselves about the safety and efficacy of current ones. We applaud NICHD's initial efforts in this area, and we strongly support the new authority for contraceptive product development outlined in H.R. 3769 which would provide additional support to boost NICHD's research into contraceptive development and evaluation.

Mr. Chairman, Planned Parenthood's primary mission is to enable all Americans to have the information and the ability to prevent unwanted or unintended pregnancy so that individuals can achieve their own family size goals. High quality low-cost services offering the safest, most effective and most acceptable methods are essential to achieving this goal. Unplanned pregnancy is indeed a national problem demanding a national solution. We look forward to working with you now and in the future in sustaining and heightening the importance of preventive, voluntary subsidized family planning services for those in need and the pursuit of better contraceptive technology for all of us, in the United States and around the world.

We thank our congressional supporters for their efforts on behalf of the Title X reauthorization in and we urge the subcommittee to move forward quickly on the Title X promptly in order that these attacks and allegations may once again be put to rest.

SUSAN WYSOCKI, B.S.N., R.N.C.N.P.
FOR THE
NATIONAL ASSOCIATION OF NURSE PRACTITIONERS IN FAMILY PLANNING
AND
NAACOG: THE ORGANIZATION FOR OBSTETRIC, GYNECOLOGIC, AND NEONATAL NURSES

Mr. Chairman and distinguished Members of the Committee, I am Susan Wysocki, a nurse practitioner who has been involved with Title X family planning programs since 1975. I am currently the Director of Public Affairs for the National Association of Nurse Practitioners in Family Planning and also serve as a clinical consultant for the Family Planning Council of Central Pennsylvania, as well as numerous other family planning programs throughout the country. Today I speak for the National Association of Nurse Practitioners in Family Planning and NAACOG: The Organization for Obstetric, Gynecological and Neonatal Nurses.

I am fortunate to have the experiences provided to me through the Title X program. I became a nurse practitioner, in 1975, by attending the Title X sponsored nurse practitioner program administered by the Planned Parenthood Federation through the New Jersey College of Medicine and Dentistry in Newark, New Jersey. Since becoming a nurse practitioner, I have provided clinical services in rural Maine, have served as the Director of Clinical Services for Maine's statewide family planning program, and have continued involvement with the Title X program in my current positions.

Nurse practitioners provide over 75% of the clinical services in Title X programs. My colleagues and I have had the opportunity to witness, first hand, the successes of the program in promoting the health and well being of the individuals in our communities. We have seen stable, healthy families grow and individuals who were able to pursue their goals because they were not faced with an untimely pregnancy. Each year at high school graduation, my colleagues and I look at the pictures of the graduating class in our local newspapers and see the faces of the young women who might not have been pictured. Because the vast majority of the young women we see are at risk for pregnancy several months before their first clinic appointment, we know that without family planning, their chances of reaching graduation would be slim. The success we have in gaining the confidence of our clients is evidenced in the fact that most of our new clients have been referred to us by a friend or family member who has visited the clinic. Our clients bring their daughters to us to talk about reproductive health and if needed, contraception. Some of these mothers, have experienced an early unplanned pregnancy themselves and know that the best chance their daughters have at a better life is by preventing the circumstances they experienced.

We have witnessed many other successes, as well. The benefits of the program reach far beyond the provision of contraceptives and the prevention of unintended conceptions. Less than one third of our patients are teens. For many of our patients, the family planning program is their only access to the health care system. Without the screening tests performed in the family planning clinic, the cervical cancers, breast cancers, hypertension and diabetes, among other diseases identified at the clinic, might go undetected. The early identification of these problems has saved lives and the health care costs associated with the treatment of disease in advanced stages.

The emphasis placed on health teaching and counseling in the family planning clinic helps our patients to take responsibility for their own health care. Instruction about monthly breast exams, and information about the prevention of sexually transmitted diseases is as important in preventing serious illness as the physical exam.

The counseling provided encourages responsible decision making about sexual behavior for adults, as well as teens. Contrary to opinions that the availability of family planning clinics encourages early or indiscriminate sexual behavior, clients are provided information that multiple sexual partners, and early initiation of sexual activity has consequences. Family planning programs respond to a need in the community. They do not create the need.

An ongoing debate about the family planning program is whether teens should be provided contraceptives without their parent's consent. As professionals, we recognize that merely providing contraceptives to a client will not make the individual an effective contraceptive user. Each of our clients has a variety of influences present in their lives that must be considered in the care of the total patient. This is one of the reasons that we do talk to our teen clients about involving their parents in their decisions to be sexually active and use contraception. For many teens, such a discussion is possible and does occur. However, for some, the discussion would only lead to increased conflict in an already troubled family.

It is unrealistic to think that family communication can be mandated. However, because nurses and other professionals are available at the clinic, the teen at least has more than just her peers to talk to about the choices she is making. Indeed, we have seen teens, who through the support provided at the clinic, learned how they could talk to their parents. Evidence consistently shows that when teens fear their parents will be notified about their visit to the clinic, they do not seek services. They do, however, continue to be at risk for pregnancy. Mandating parental consent would only isolate teens from help.

Another, more recent controversy, has been the attempts to prohibit full pregnancy options counseling to women seen in Title X clinics. This is of great concern to the nurses working in the clinics and merits comment to this Committee. The use of federal dollars to fund abortion is already prohibited. Attempts to restrict comprehensive counseling, even when requested by the client, is a violation of standards of nursing practice.

While the nurses in our organizations hold a variety of opinions about abortion, there is agreement that the nurse's role is never to promote a particular choice for any health care alternative. Rather, it is the nurse's role to provide her patient with the information she needs to make her own decision about her options. It is neither the nurse's nor the government's responsibility to make her decision for her. Counseling that is structured to deliberately seek a predetermined outcome is ethically irresponsible.

Finally, I would like to address the need for the continued support for funds for the education of OB/GYN nurse practitioners to provide the direct clinical services in family planning clinics. These nurse practitioner programs are essential for maintaining high quality family planning programs. Because Title X nurse practitioner programs are similar in content, the graduates of these programs ensure the consistency of family planning services throughout the country. In addition to providing high quality, cost effective clinical services, the nurse practitioner's specific body of knowledge makes her a valuable resource for others in the clinic. Nurse practitioners are the professional backbone of the family planning program.

Family planning programs are experiencing their own version of the nursing shortage. In talking with clinic administrators across the country, the unavailability of nurse practitioners is the single most important problem they are currently facing. A vacant nurse practitioner position can cripple a clinic's operation. It can mean that the limited financial resources of the clinic will have to be spent paying a physician (assuming one can be found) for the services that nurse practitioners are educated to provide. The National Association of Nurse Practitioners has recognized the need to address the current shortage and will be investing the scope of the problem. A position paper on possible solutions to the address the issue will be completed sometime in July of 1988. Those results can be shared with this Committee. Before that time, however, support of the reauthorization of the Title X program is imperative to ensure that the problem is not compounded.

In conclusion, all too often, the benefits of the family planning program are mired in the controversies that have been created. Some of those issues have been necessarily addressed in this testimony. Despite the controversies, the positive outcomes of the Title X program cannot be factually disputed. The real evidence of the success of Title X comes from the nearly five million individuals in this country who continue to utilize family planning services and continue to be helped by the program. The evidence comes from the clients we, as nurses, see every day... clients, whose major concerns with the controversies focus on the possible threats these controversies pose to the existence of the health care services they rely on.

Therefore, we urge this Committee to support reauthorization of the Title X program to ensure its continuation. Furthermore, we urge you to maintain the integrity of the program as it has served men an women in this country for over 17 years by opposing any restrictive amendments to the legislation.

Thank you for your consideration.

TESTIMONY
OF
THE NATIONAL FAMILY PLANNING
AND
REPRODUCTIVE HEALTH ASSOCIATION

The National Family Planning and Reproductive Health Association, Inc. (NFPRHA) appreciates this opportunity to testify in support of the reauthorization of the national family planning program -- Title X of the Public Health Service Act. In particular, NFPRHA endorses the passage of H.R. 3769, the reauthorization legislation introduced by Representatives Waxman and Madigan.

NFPRHA is a non-profit membership organization headquartered in Washington, D.C., established to improve and expand the delivery of voluntary family planning and reproductive health care services throughout the United States. As the only national organization representing the entire family planning community, NFPRHA's members comprise almost the totality of grantees under the national family planning program, Title X of the Public Health Service Act. NFPRHA represents over 83 percent of the Title X grantees across the United States who, in fiscal year 1987, received nearly 90 percent of the Title X family planning service dollars. Among those NFPRHA represents are hospitals; state and local health departments; affiliates of the Planned Parenthood Federation of America; independent non-profit family planning agencies; individual doctors, nurses, and researchers; and consumers of reproductive health care providers. NFPRHA is committed to establishing and maintaining reproductive health care as a high priority preventive health care service in this country.

TITLE X -- A NECESSARY PUBLIC HEALTH PROGRAM

In a message to the Congress in July 1970, President Richard M. Nixon stated,

> It is my view that no American woman should be denied access to family planning assistance

> because of her economic condition. I believe, therefore, that we should establish as a national goal the provision of adequate family planning services within the next five years to all those who want them but cannot afford them. This we have the capacity to do.

The Family Planning Sevices and Population Research Act (P.L. 91-572) subsequently was signed into law in December, 1970. During the seventeen years since then, the national family planning program has been an intregral component of the panoply of programs designed to improve public health in the United States.

Title X is primarily a health services program that serves the poor and medically indigent. Through a network of over 4,000 clinics, family planning agencies serve as the entry point for millions of low-income women and adolescents into the nation's health care system. For many, it is the only source of health care readily available.

This network is incredibly diverse, with providers of varied types offering family planning services with Title X funds. State and local health departments constitute the single largest group of providers, serving 40 percent of Title X clients. Affiliates of the Planned Parenthood Federation of America serve 27 percent of the clients; hospitals, 13 percent; and a variety of other agencies such as health maintenance organizations, community health centers, and independent clinics serve the remaining 20 percent.

This network, established and operated under the Title X program, provides the infrastructure for the organized delivery of publicly-funded family planning services. While Title X is the single largest source of public support for family planning -- providing over one-third of the total public family planning funds -- it is augmented by: the Maternal and Child Health Block Grant (Title V of the Social Security Act); Medicaid (Title XIX of the Social Security Act); the Social Services Block Grant (Title XX of the Social Security Act); state and local funding; patient fees; other third party reimbursements; and private philanthropy.

The average Title X client is young, female, and has a low or marginal income. Sixty-nine percent of the clients are white, and eighty percent have incomes below 150 percent of the federal poverty level.

Typical Title X programs offer clinical health services (physical examinations; contraceptive information and services, including natural family planning; Pap smears; sexually transmitted disease screening and treatment; cancer screening; hemoglobin tests; urinalysis; pregnancy testing and diagnosis; and basic gynecolgic care); counseling services (for nutrition, infertility, parent/teen communication, maternal and child health, and related medical problems); services for men (counseling, education, condoms); special teen clinics; adolescent health education; and community education programs.

The need for the Title X program is clear and considerable. Although 3.5 million low-income women and 1.5 million adolescents receive services yearly from Title X clinics, 56 percent of the over 9.5 million low-income women and 69 percent of the five million sexually active teenagers in need of subsidized family planning services still cannot obtain medically supervised reproductive health care.

Hundreds of thousands of unintended pregnancies, many among teenagers, are averted each year as a direct result of services provided by clinics receiving Title X funds.

Even with Title X, over fifty percent of the six million pregnancies yearly in this country are unintended; 1.1 million of those pregnancies are to teenagers. Eighty percent of all teenage pregnancies are unintended. Over 1.5 million abortions occur each year, more than 400,000 to teenagers.

Pregnancies avoided by the utilization of Title X family planning services limit the numbers of abortions and unintended births that occur each year in the United States.

Department of Health and Human Services Secretary Otis R. Bowen has noted, "Between their 13th and 19th birthdays, more than one quarter of all teenage girls will be pregnant at least once. Pregnancy among unmarried teens is a problem for both the girls having babies and the boys who father them. And it is a problem we all must face...not just the government, but all of us."

That problem is not simply whether a pregnant teenager chooses to give birth or to have an abortion. As the Center for Population Options documented in its 1986 study on the public costs of teenage childbearing,

> The more than one million teenage pregnancies that occur each year are a serious problem for all of society. Not only is teenage childbearing a threat to the health and welfare of the mother and child, but adolescent pregnancy contributes to such societal problems as poverty, unemployment, family disintegration,

juvenile crime, school dropouts and child abuse.

Thus, the federal dollars invested in Title X to prevent pregnancy more than pay for themselves in savings in public health care and social service costs.

Unfortunately, despite the Presidential call for total access to family planning services by 1975, federal, state, and local financial support for family planning has never reached a level commensurate with need. Since the early 1970's the number of medically indigent family planning clients has grown more than 60 percent, yet federal funding for family planning has not increased in real dollars since 1973.

Congressional passage of H.R. 3769 will go a long way to ensuring that low-income women and sexually active teenagers will not have to go without the family planning services they so desperately desire and need to prevent unintended pregnancies and the severe consequences associated with such pregnancies.

H.R. 3769 -- A STEP FORWARD

The authorization of the Title X statute expired on September 30, 1985. For the last three fiscal years, the Title X appropriation has been carried on a series of Continuing Resolutions. The result has been limited, inadequate funding levels for the family planning program since October, 1985.

In the fiscal year 1981, the appropriation for all programs under Title X statute was $162 million. That figure dropped to $124.8 million in fiscal year 1982, $124 million in fiscal year 1983, $140 million in fiscal year 1984, and $142.5 million in fiscal year 1985. In fiscal year 1986, the Gramm-Rudman-Hollings reductions cut Title X funding to $136 million, while in fiscal year 1987, without Gramm-Rudman-Hollings reductions, the Title X appropriation was raised once again to $142.5 million. For this fiscal year, 1988, the Title X funding has again gone down to $136.3 million. Inflationary figures alone should have brought the current level of Title X funding to $216 million by this year.

According to DHHS figures, the funding reductions in the early 1980's forced the closing of almost 1,000 clinics and the curtailment of many services. Operating hours have been reduced, staff have been cut, and indigent patients have been asked to contribute more to the cost of services. The irony of this, is of course, that reducing a program as effective and cost-efficient as Title X results only in far greater social and financial costs down the line.

By providing modest increases in the authorized funding levels for basic family planning services, and for training programs and technical assistance programs, enactment of H.R. 3769 will permit the restoration of some services and the provision of preventive reproductive health services to additional clients.

The minor programmatic changes proposed in H.R. 3769 will ensure the collection and analysis of appropriate data; more clearly define the type of research projects that should be funded to investigate methods to improve service delivery; assure the continued clinical training of family planning nurse practitioners; and remove from the statute an unnecessary funding provision that has never been utilized.

The two major new initiatives proposed in H.R. 3769 address vital needs for the American public. The limitations in number, quality and efficacy of current contraceptive methods require the intensive effort to develop, market and evaluate new contraceptive devices, drugs and methods proposed by Section 5 of H.R. 3769.

And, with the understanding that "knowledge is power," H.R. 3769 would increase the knowledge of individuals -- particularly teenagers and their parents -- about methods to prevent unintended pregnancy and the contraction of sexually transmitted diseases through the enhancement of the public, community-based information and education programs funded under Title X.

The National Family Planning and Reproductive Health Associaation wholeheartedly endorses the passage of H.R. 3769 and the reauthorization of the Title X family planning statute for three years, through fiscal year 1991.

TITLE X -- SURVIVING EIGHT YEARS OF HARASSMENT

Despite Title X's record of accomplishment, the Reagan administration has consistently sought to repeal the Title X program for ideological and political reasons, and failing that, to significantly reduce the program's funding and undertake administrative harassment designed to destroy the integrity and efficacy of the national family planning program.

However, Congressional and public recognition of Title X's important public health role has enabled the program to withstand eight years of assault by the Reagan administration and its anti-family planning allies.

The litany of actions inimicable to the Title X statute and the best interests of high quality family planning service delivery is seemingly endless. Among the highlights of the last eight years are:

1. The consecutive appointment as Deputy Assistant Secretary

for Population Affairs charged with administering the national family planning program of three individuals who are personally opposed to the program.

2. The refusal since 1982 to appoint a qualified public health professional and administrator as Director of the Office of Family Planning within OPA.
3. The proposing -- eight times -- of the repeal of the Title X family planning statute and its replacement with a block grant designed to undermine the delivery of comprehensive, high quality family planning sevices throughout every state and region.
4. The proposing of major budget cuts and the impoundment of appropriated Title X funds in fiscal year 1982 which were released only upon the filing of a lawsuit by NFPRHA and others.
5. The institution of an unprecedented number of audits of family planning providers by the DHHS Office of Inspector General.
6. The transfer of the Office of Family Planning from the complex of professionally-administered public health programs in the Bureau of Health Care Delivery and Assistance to a place of isolation in the Office of the Assistant Secretary for Health.
7. The "de-funding" of grantees under the Title X service delivery improvement program because of their opposition to the Reagan administration's anti-family planning efforts.
8. The promulgation of the "squeal rule" -- regulations to

require parental notification for the provision of prescription contraceptives to minors -- that was struck down by federal courts as antithetical to the Title X statute in a lawsuit brought by NFPRHA and others.

9. The proposal by the Office of Management and Budget -- withdrawn after a two year outcry -- to prohibit "public advocacy" with non-federal funds by Title X and other federal grantees.

10. The promulgation of the "gag rule" -- regulations under which pregnant poor women receiving medical care from Title X family planning clinics would not be able to obtain any abortion-related information or counseling -- enjoined by a permanent injunction in federal court in a lawsuit brought by NFPRHA and others. The court found the gag rule illegally contravening the intent of Congress in establishing the Title X program, violating medical ethics and practice standards, and unconstitutionally interfering with the First Amendment and privacy rights of women and their physicians to discuss legal medical options of care.

Most recently, through a series of pointed administrative efforts to substitute political ideology for statutory requirements, the resources of the Department of Health and Human Services have been misapplied to undermine the delivery of family planning services through Title X.

Last year, it appeared that the personal anti-abortion philosophy of the former Deputy Assistant Secretary for Population Affairs (DASPA), Mrs. Jo Ann Gasper, and her senior advisors distorted the administration of the Title X program -- a program designed to prevent abortion through preventive family planning services. In media interviews, and personal appearances, Mrs. Gasper had implied that her personal loyalties and convictions led her to implement the Title X program in a way that was in contradiction to seventeen years of DHHS' policy, in contradiction to DHHS General Counsel advice, and most importantly, even in contradiction to Title X's statutory history and Congressional intent. This, in the end, resulted in her dismissal.

Unfortunately, through its new DASPA, N. Nabers Cabaniss, DHHS has not disavowed the actions of the former DASPA nor indicated that the family planning program will now be administered in a professional and competent manner. Ms. Cabaniss is the third DASPA in a row who is opposed to the Title X program. In prior positions, Ms. Cabaniss supported and undertook efforts to undermine the Title X program.

The major controversies contrived by officials of DHHS over the years severely diminishes the Public Health Service's credibility and its ability to perform required monitoring and support of family planning programs. These actions distract those Title X-funded agencies from the appropriate provision of high quality services to their clients. The controversies disrupt planning and budgeting by family planning agencies and hinder the day-to-day operations of the clinics by the distractions and uncertainties they create.

Numerous DHHS Office of the Inspector General (OIG), U.S. General Accounting Office (GAO), Congressional and other investigations and audit reviews have demonstrated strict compliance by Title X grant fund recipients with the terms, conditions and intent of the Title X statute, its regulations and guidelines regarding Section 1008 of the law (denying the use of Title X funds in programs where abortion is a method of family planning.) Nonetheless, OPA has consistently attempted to force the denial of Title X funds to agencies that provide abortions with non-federal funds, or even even provide non-directional counseling and referral for pregnancy termination in compliance with Title X's own rules.

The extraordinary efforts DHHS and OPA have undertaken to formulate the enjoined Gag Rule and other ideological attacks on the family planning program have precluded any competent effort to address the appropriate administrative and managerial concerns facing Title X projects today. The following is only a short list of the many items of crucial importance that are being ignored, or improperly handled by the DHHS Office of Population Affairs:

1. The formula for allocating Title X service dollars is woefully out-of-date, yet the only effort to revise it resulted in a program motivated by a philosophy designed to skew funding from cost-efficient preventive family planning services requested by clients to more costly, seldom requested services. So poorly-prepared was the formula that members of the Congressional appropriations committees stepped in to block its implementation during fiscal year 1987 with report language in the Continuing Resolution.
2. The spread and treatment of sexually transmitted diseases such as chlamydia and penicillin resistant gonorrhea requires uniform advice from OPA, yet OPA has not provided any direction to the projects it administers.
3. The publication of notices of requests for Title X grant

applications, and the awarding of grants and contracts, has occured consistently late, creating major dislocations for the for the providers of family planning services and training programs.

4. Requests for grant proposals have included, or attempts have been made to include, new and unique requirements designed to limit or deny grant awards to current training and service grantees of whom OPA, apparently personally, disapproves, despite those grantees more-than-competently meeting the terms and conditions of their current grants.
5. While refusing to address current management priorities despite repeated requests from grantees for advice and assistance in those areas, OPA has repeatedly undertaken studies and issued directives with no apparent relationship to the direct competent provision of high quality and family planning health care.
6. Although limited effort is made to administer the Title X program in compliance with good management practices, OPA misspent considerable time and resources in a short-lived attempt to change the Title X guidelines regarding the provision of non-directional counseling and referral on options for the management of an unintended pregnancy in direct contravention to statutory and constitutional requirements.
7. Requests for grant proposals have included or attempts have been made to include, new and unique requirements designed to limit or deny grant awards to current training and service grantees of whom OPA disapproves, despite those grantees more-than-competently meeting the terms and conditions of their

current grants.

Title X funds have never susidized abortion procedures. Yet, under the guise of opposing abortion, some individuals in DHHS and Congress, and some organizations opposed to family planning, have made unsubstantiated and incorrect allegations about the program so as to undermine the single most effective federal effort for reducing the need for abortion -- the national Title X family planning program.

THE FACTS SHOW STRICT COMPLIANCE WITH THE LETTER AND INTENT OF SECTION 1008 BY TITLE X PROVIDERS

Throughout the eighteen year history of the Title X program, family planning providers have been scrupulous in their adherence to the letter and intent of the law and all appropriate regulations. Despite this demonstrable fact, family planning opponents continue to assert that Title X funds are being provided improperly to certain family planning agencies or being misused by family planning agencies.

In particular, the charge is made that there is a "taint of abortion and abortion-related activities" that must be removed from the Title X family planning program. Those who make this charge claim that agencies that provide abortions or abortion related services -- with non-federal funds -- are prohibited by the Title X statute and Congressional intent from receiving Title X funds; for eighteen years, they declare, DHHS has been funding such agencies illegally.

Further, these family planning opponents state, there is a "perceived entanglement" of abortion with the Title X family planning program and that family planning providers illegally misuse their federal dollars to provide abortions or engage in prohibited abortion-related activities.

These allegations are baseless and wholly without substance. At best they are inaccurate and misleading. At worst, they are simply untrue.

Congress enacted P.L. 91-667 in 1970, prior to the United States Supreme Court's Roe v. Wade decision legalizing abortion throughout the country. In 1970, abortion was proscribed in many states, but legal in others. That year, Congress included in the original family planning statute a provision that remains unchanged today: "Section 1008 -- None of the funds appropriated under this title shall be used in programs where abortion is a method of family planning."

The December 3, 1970 conference report to accompany the Title X bill [House Report 91-1667 to accompany S. 2108] stated Congress' intent:

> It is and has been the intent of both Houses that the funds authorized under this legislation be used only to support preventive family planning services, population research, infertility services and other related medical, information, and educational activities. The Conferees have adopt- the language in Section 1008, which prohibits the use of such funds for abortion, in order to make clear this intent. The legislation does not and is not intended to interfere with or limit the programs conducted in accordance with state or local laws and regulations which are supported by

funds other than those under this legislation.

Simply stated, Congress specifically provided that agencies in states where abortion was legal in 1970 could operate under those state laws regarding abortion and still receive Title X funds for family planning services programs. Those agencies, however, could not utilize Title X funds for abortions. Thus, under original Congressional intent and edict, agencies involved in abortion with non-Title X funds can and do receive Title X funds for their family planning programs. They operate their Title X family programs appropriately and legally segregated from any prohibited activities, in full compliance with Section 1008.

Further buttressing the validity of the original Congressional intent in enacting Section 1008, in November 1986, the U.S. Supreme Court struck down an Arizona law that attempted to prohibit the provision of state funds to agencies involved in abortion with non-state funds, a situation directly analagous to the argument presented by Title X's opponents. By a 5 to 3 vote, in Babbitt v. Planned Parenthood of Central and Northern Arizona, the court summarily affirmed a U.S. Court of Appeals decision which held it unconstitutional for states to deny family planning funds to private organizations because they legally provide abortions or offer related counseling and referral services with non-state funds.

Opponents of the Title X program claim that Title X funds are inappropiately subsidizing abortions through the "numerous" agencies at which abortions are provided in the same facilities as are family planning services. Further, they claim that providing information to pregnant women about the availability of abortion through nondirective counseling and referral by Title X programs is illegal "advocacy of abortion." Finally, they charge that agencies which are supportive of abortion as a legal option and who advocate for that position with non-federal funds cannot recieve Title X funds without their advocacy position interfering with their ability to comply with Section 1008 and to provide qualilty family planning services as mandated by Title X.

DHHS's own materials document the absurdity of these canards. According to the latest DHHS figures, out of 4,000 Title X family planning clinics, at only 74 clinics are abortions also performed -- without Title X funds. It is especially noteworthy that, of those 74, 63 percent (or 46 Clinics) are located in hospitals. The remainder are Planned Parenthood affiliates (21), other non-profit organizations (4), and public health departments (3).

Since the inception of the program, DHHS' Title X regulations have required physicans and other clinicians to "provide for medi-
cal services related to family planning... and necessary referral to other medical facilities when medically indicated" and to "provide for social services related to family planning, including counseling, referal to and from other social and medical service agencies...." Thus, pregnancy-related counseling and referral services are an inappropriate part of the program.

In accord with the regulations, with the accepted medical standards promulgated by the American Medical Association and the American College of Obstetricians and Gynecologists, and with the United States Constitution, the Title X guidelines specifically require that women facing an unintended pregnancy are to be provided with non-directive information and counseling, and referral upon request, for all their legal options: prenatal care and delivery; infant care, foster care or adoption; and pregnancy termination.

Neither the DHHS Office of Inspector General (OIG) nor the General Accounting Office (GAO) have been able to substantiate the allegations that family planning agencies have used Title X funds to subsidize abortions in co-sited clinics or advocate abortion through counseling and referral. Rather, the contrary is true.

In its last (1982) report on this subject, the GAO stated that it "found no evidence that title X funds have been used for abortions or to advise clients to have abortions."

In the rash of audits in 1981 and 1982, the DHHS OIG repeatedly declared the falsity of the allegations. Typical qoutes in audit reports stated, "[W]e determined that (agency) did not use Title X funds for abortion-related activities;" "Our tests of expenditures did not disclose any problems in terms of accountability for such funds or provide any indications that Title X funds were used for unallowable purposes;" "We found no expenditures that were in violation of the Act [Title X] or other regulatory requirements;" and "We found no evidence that [agency] was providing abortion-related services to family planning clients of using Title X funds for direct abortion services."

More recently, in testimony before the House Subcommittee on Health and the Environment in both 1984 and 1985, and again in testimony before the House Appropriations Subcommitte on Labor, HHS and Education in February 1987, former DHHS Secretary Margaret M. Heckler and current Secretary Bowen specifically reaffirmed that Title X clinics are in full compliance with the Section 1008 prohibitions.

In conclusion, there is not a scintilla of evidence that Title X family planning agencies are in violation in any way with Section 1008. Allegations to the contrary must be seen for what they are: efforts to harass, discredit and undermine the family planning program under Title X.

NFPRHA asks this subcommittee and the Congress to focus not on unfounded allegations, but on the well-documented public health need and successes of the national Title X family planning program. NFPRHA urges the swift enactment of H.R. 3769 and the reauthorization of the Title X statute.

NFPRHA asks, Mr. Chairman, that in light of the recent litigation against the administration's gag rule and since this association has the only successful lawsuit that was recently granted a permanent injunction in federal court to block impmementation of these regulations that would hopelessly cripple the Title X program, that the attached legal documents pertinent to any discussion of the future of Title X be included in the hearing record.

Mr. Chairman and Members of the Subcommittee, thank you very much for your attention to NFPRHA's testimony.

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

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ACTION FOR BOSTON COMMUNITY
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HEALTH AWARENESS SERVICES OF
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Civil Action No. _____

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Plaintiffs,

v.

OTIS R. BOWEN, SECRETARY, U.S.
DEPARTMENT OF HEALTH AND HUMAN
SERVICES
Room 516H, Humphrey Building
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Washington, D.C. 20201

Defendant.

COMPLAINT FOR DECLARATORY, INJUNCTIVE AND OTHER RELIEF

Purpose of Action

1. This is an action brought to declare invalid and preliminarily and permanently enjoin the implementation of

regulations issued on February 2, 1988,[1] under Title X of the Public Health Service Act, 42 U.S.C. § 300 et seq. (hereafter "Title X").[2] These regulations reverse long-standing agency interpretation and implementation of the provisions of Title X without any intervening change in the law, are contrary to legislative purpose and intent, and violate the constitutional rights of Title X grantees and their patients.

2. The new regulations scheduled to become effective in parts -- in 30 days for some requirements and 60 days for others -- constitute a radical departure from present standards and requirements. They: (1) prohibit a Title X "project" from engaging in any post-pregnancy counseling, including counseling on abortion or abortion referral;

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[1] The U.S. Department of Health and Human Services, which administers Title X, has announced that the regulations will be formally published in the Federal Register on February 2. Plaintiffs have obtained in advance a typed executed copy of the regulations and have used that copy in preparing this complaint. Plaintiffs will soon advise the court of the proper Federal Register citation.

[2] Technically, the authorization for Title X (42 U.S.C. § 300(c)) has expired. However, Title X has been kept in existence through a series of continuing resolutions/appropriations statutes. The current such "authorization" (for fiscal year 1988) is Public Law 100 - 202, An Act Making Appropriations for the Departments of Labor, Health and Human Services, and Education, and Related Agencies, for the fiscal year ending September 30, 1988, and for other purposes, Title II (appropriation for Health Resources and Services Administration), H. Rpt. No. 100-498, Dec. 22, 1987, p. 275.

(2) effectively require a Title X recipient that is willing to use its own funds and resources to counsel on or refer for abortion (or to provide abortion services) to do so in a separate physical setting with separate staff, bookkeeping, and identification; and (3) condition receipt of Title X funds on the forfeit of First Amendment, privacy, and other constitutional rights.

3. The new regulations will result in incomplete, unethical, and potentially dangerous medical practices by Title X grantees; expose patients to unwarranted, unnecessary, and unlawful risks by depriving them of essential information; and systematically undermine the Title X program as contemplated by Congress.

The Parties

4. Plaintiff, Commonwealth of Massachusetts, has a vital interest in the general health and welfare of its citizenry and brings this action, parens patriae, on behalf of more than 80,000 Massachusetts citizens now served by, and all Massachusetts citizens entitled to services under, the Title X family planning program, especially those who are poor and adolescent and unable to represent themselves, and who may suffer severe and irreparable harm to their physical well-being if these regulations are implemented. Plaintiff also brings this action in its proprietary capacity to assure that Massachusetts citizens receive the full benefit of the family

planning program to which they are entitled under federal statutory law. The implementation of these regulations would place an economic strain on the Commonwealth, which will have to compensate for program closings and the loss of services expected to follow implementation and enforcement of these regulations. The Commonwealth, finally, brings this action to ensure that its laws and policies are not unlawfully preempted.

5. Plaintiff, National Family Planning and Reproductive Health Association, Inc. ("NFPRHA"), is a non-profit membership corporation organized and existing under the laws of the District of Columbia, with its offices and principal place of business located in the District of Columbia. NFPRHA was established to improve and expand the delivery of family planning and reproductive health care services throughout the United States. NFPRHA's membership was originally made up exclusively of agencies receiving funds under Title X. Although NFPRHA's membership is no longer limited in this fashion, NFPRHA has retained its predominantly Title X membership and focus. Among NFPRHA's members are representatives of over 85 percent of the recipient organizations that administer Title X funds. With over 900 members, NFPRHA is the only national family planning organization that brings together consumers and health care professionals, including State,

county and city health departments, Planned Parenthood Federation of America affiliates,[3/] hospital-based clinics, "umbrella" family planning councils, independent, free-standing family planning clinics and other family planning organizations and providers.

6. Plaintiff, American Public Health Association ("APHA"), is a national non-profit organization established in 1872 in the District of Columbia with the objective of protecting and promoting personal health. APHA is the largest public health organization in the world, with a membership of about 50,000. Within APHA is the Population and Family Planning Section, with 1027 members. This Section includes health care professionals who work in family planning clinics funded by Title X. APHA brings this action on behalf of its members who are employed in Title X clinics.

[3/] The Planned Parenthood Federation of American is bringing a similar action in another district court on behalf of the members of the Federation. To avoid any conflict, NFPRHA brings this action on behalf of its other than roughly 100 Planned Parenthood members. The NFPRHA members on whose behalf this action is brought include approximately 350 recipients of Title X funds of which 65 are direct (as distinguished from State or private organizational "subgrantees") Title X grantees. Since there are only 88 direct Title X grantees, NFPRHA in this action is representing nearly 75 percent of the agencies and organizations that have primary Title X grants, which receive about 85 percent of the funds available for Title X services. All named plaintiffs, except for the Commonwealth of Massachusetts, the American Public Health Association, and NFPRHA itself are NFPRHA members. NFPRHA members on this complaint include, inter alia, all of the organizations administering Title X programs within the States of Massachusetts, California, and Missouri.

7. Plaintiff, Family Planning Council of Western Massachusetts, Inc., a NFPRHA member, is a non-profit corporation organized under the laws of the Commonwealth of Massachusetts, with its offices and principal place of business in Northampton, Massachusetts. It is a current recipient of Title X funds, and it received $564,664 in Title X funds in fiscal year 1987. The Council is a private health care organization that provides comprehensive family planning education, training, and medical services within the 3,000 square mile Western Massachusetts region to over 13,000 clients (annually) at 11 medical sites, two of which are co-sited with clinics providing abortion services. Approximately 95 percent of the clients who utilize the services of the Council need the subsidy provided by the Title X grant.

8. Plaintiff, Healthworks - A Family Life Resource Center ("Healthworks"), a member of NFPRHA, is a non-profit, tax-exempt corporation organized under the laws of the Commonwealth of Massachusetts. Healthworks primarily serves individuals within the Merrimack Valley as a current direct Title X grantee. In fiscal year 1987, Healthworks received $359,000 in Title X funding and provided family planning services in four clinic sites to over 9300 persons.

9. Plaintiff, Action for Boston Community Development, Inc. ("ABCD"), a member of NFPRHA, is a non-profit, tax-exempt corporation organized in 1982 under the laws of the

Commonwealth of Massachusetts. ABCD primarily serves the City of Boston as a current direct Title X grantee. In fiscal year 1987, ABCD received approximately $847,000 in Title X funding. ABCD provides family planning services through a combination of direct provision of educational, outreach, supplies, and laboratory tests as well as subgranted medical and counseling services to over 25,000 clients (annually) at 25 sites including community health centers and hospital outpatient departments. Five ABCD sites are located within the physical and organizational structures of hospitals where abortions are performed.

10. Plaintiff, Health Awareness Services of Central Massachusetts, Inc. ("HASCM"), a NFPRHA member, is a private non-profit corporation organized under the laws of the Commonwealth of Massachusetts. HASCM, a current Title X recipient, received $420,148 in Title X funds in fiscal year 1987. HASCM directly provides family planning services in free-standing clinics and in community hospitals and also subgrants to three other health care providers for Title X services to over 9000 clients in central and southern Worcester County, including the City of Worcester.

11. Plaintiff, Health Care of Southeastern Massachusetts, Inc. ("HCSM"), a NFPRHA member, is a private, non-profit corporation organized under the laws of the Commonwealth of Massachusetts. HCSM, a current Title X recipient,

serves the counties of Norfolk, Plymouth, Bristol, Dukes, and Nantucket, representing the entirety of southeastern Massachusetts, and received over $604,000 in Title X funds during fiscal year 1987, of which $150,000 was distributed to other agencies, for the provision of comprehensive family planning services to 17,000 clients.

12. Plaintiff, California Family Planning Council ("CFPC"), a member of NFPRHA, is incorporated under the laws of California and was established for the purpose of administering all Title X funding in California except for the funds allocated for Los Angeles County. CFPC currently administers approximately $8 million in Title X funds, subgranting to 50 agencies throughout the State that provide services annually to over 220,000 individuals in approximately 120 different clinic sites. At least 7 non-county agencies and several county hospital clinics with which CFPC contracts are co-sited with abortion clinics.

13. Plaintiff, Los Angeles Regional Family Planning Council, Inc. ("LARFPC"), a member of NFPRHA, is incorporated in California as a non-profit private entity and was established for the purpose of administering funding for family planning services in Los Angeles County. LARFPC currently subgrants Title X funding to over 30 agencies that operate approximately 100 clinic sites and provides services to over 150,000 individuals each year. LARFPC received approximately

$4.4 million in Title X funds in fiscal year 1987. At least 8 of the clinic sites with which LARFPC contracts are co-sited with abortion clinics.

14. Plaintiff, Missouri Community Health Corporation ("MCHC"), a NFPRHA member, is a private non-profit organization incorporated in the State of Missouri. It provides services throughout Missouri (107 counties), with the exception of St. Louis and 6 St. Louis suburban counties. MCHC is a direct Title X grantee receiving and administering approximately $1.8 million in Title X funds through a network of 15 local agency service providers, making services available to over 52,000 women. Two of the sites are co-sited with abortion clinics.

15. Plaintiff, Family Planning Council of Greater St. Louis ("FPCGSL"), a member of NFPRHA, is a non-profit corporation organized under the laws of Missouri. FPCGSL serves clients in an eight-county area of eastern Missouri. It is a current Title X grantee, having received $1.3 million in fiscal year 1987. FPCGSL arranges direct family planning services through subgrants to 12 organizations that operate 25 service sites, providing services to 31,00 clients.

16. Plaintiff, Family Planning Council of Southeastern Pennsylvania ("FPCSP"), a NFPRHA member, is a private non-profit corporation organized under the laws of the Commonwealth of Pennsylvania. FPCSP, a current Title X recipient,

received $2.5 million in Title X funds in fiscal year 1987. It subgrants to 18 agencies to provide services to over 90,000 clients in 5 counties, including Philadelphia. Eleven of the family planning sites are co-sited with abortion service facilities.

17. Plaintiff, Martin Freifeld, M.D., a member of NFPRHA, is the Medical Director of Maternal and Family Health Services, Inc., one of the current Title X grantees in Pennsylvania. Dr. Freifeld not only provides medical administration services to the Title X grantee but also personally provides family planning services to Title X clients through the program. He sues on his own behalf.

18. Plaintiff, Steven J. Sondheimer, M.D., a member of NFPRHA, is Director of the Family Planning Program at the Hospital of the University of Pennsylvania. The Family Planning Program receives Title X funds and provides a broad range of family planning services to adults and minors in the Philadelphia area. Dr. Sondheimer himself not only administers the Family Planning Program, but also personally provides family planning services to adults and minors through the program. He sues on his own behalf.

19. Defendant, Otis R. Bowen, is the Secretary of the U.S. Department of Health and Human Services ("HHS"), and as such is charged with the responsibility for administration

of the family planning program authorized under Title X. He is sued in his official capacity.

Jurisdiction and Venue

20. This action arises under the Constitution and laws of the United States. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1361 and 5 U.S.C. § 702. Plaintiffs seek a declaratory judgment pursuant to 28 U.S.C. § 2201 and 2202 and related equitable relief pursuant to 28 U.S.C. § 1651. Venue is proper under 28 U.S.C. § 1391(e).

General Allegations

21. On February 2, 1988 defendant published certain changes to regulations implementing Title X. These regulations radically alter the manner in which recipients of grants of assistance under Title X must administer the family planning program and are contrary to Title X, medical ethics, and the U.S. Constitution. Plaintiffs bring this action for a declaratory judgment and injunctive and other relief in order to prevent defendant from implementing and enforcing his unlawful new regulations.

Background

22. On September 1, 1987, HHS published proposed Title X regulations in the Federal Register, 52 Fed. Reg. 33210 (Sept. 1, 1987), and asked for public comment.

23. Tens of thousands of comments were filed in response to the request, including those from plaintiffs Commonwealth of Massachusetts and NFPRHA. Plaintiffs' comments registered vigorous opposition to all aspects of the proposed regulations. Despite such comments from plaintiffs and similar comments from numerous Title X funding recipients, members of the medical community, and other interested parties, HHS has issued new regulations in final form that are virtually the same as those originally proposed.

24. The new regulations have been issued at the direction of the President. The President issued a series of directives to HHS on July 30, 1987, with which HHS complied by issuing the proposed Title X regulations.

Description of Title X

25. Title X is the single largest voluntary family planning program funded by the Federal Government. Originally enacted as a part of the Family Planning Services and Population Research Act of 1970, Title X authorizes the Secretary of HHS to make grants to public and private non-profit entities to assist in the establishment and operation of voluntary family planning projects that offer comprehensive family planning services. Such comprehensive services include prescribing contraceptives, testing for pregnancy or disease, family planning, counseling pregnant women on all options available to them, including abortion, and referring women to

other medical providers when indicated or requested. More than one-third of all public support for family planning services comes from Title X.

26. The program's focus is on providing services to a population of approximately 14.5 million women at risk for unintended pregnancy, including 5 million adolescent women ages 15 - 19, and 9.5 million adult women ages 20 - 44, in families with incomes below 150 percent of poverty. The program also serves numerous women who are able to afford to pay for the cost of Title X's family planning services and whose fees are used by Title X recipients to supplement the amount of funds available for services to low-income women.

27. In general, Title X grant funds pay for only a portion of the overall family planning services provided by a Title X recipient. Revenues from private fees or public (e.g. Medicaid) or private insurance are used to "match" funds received from Title X (as well as to expand a recipient's services or activities). There are approximately 4,500 clinics providing Title X services throughout the United States.

Specific Allegations

Current Regulations and Guidelines

28. Since Title X's enactment, HHS has interpreted the statute through regulations, guidelines, and publically disseminated opinions of HHS' Office of General Counsel to require comprehensive medical information and referral,

including not only comprehensive medical exams, screening for sexually transmitted diseases, pregnancy testing, birth control counseling and education, infertility services, and provision of all contraceptive methods, but also complete post-pregnancy counseling (including non-directive counseling on all options including abortion) and referral to abortion providers. HHS has also consistently interpreted Title X to mean that Title X providers may share their facilities with abortion providers as long as their funds are not commingled. On numerous occasions, Congress has rejected legislative attempts to limit the abortion counseling and referral activities that were being carried out by grantees in accordance with HHS' statutory interpretations.

29. More concretely, the current regulations, guidelines, and opinions being replaced provide for the following under Title X:

(1) That all pregnant Title X clients must be counseled on all options, including abortion. Part II, 5, 8, 6, Program Guidelines for Project Grants for Family Planning Services (hereafter "the Guidelines"), Public Health Service of HHS, 1981, p. 12 - 13. See also 42 C.F.R. § 59.5(b)(2);

(2) That upon being so counseled, a woman must, at her request, be referred for abortion.[4/]

[4/] Pregnant clients also must be referred for abortion where medically indicated.

Guidelines, § 10.1, p. 15. See also 42 C.F.R. § 59.5(b)(1); and

(3) That the agency or organization receiving Title X funds may also operate an abortion clinic and even co-locate that clinic with its Title X program as long as it separately accounts for its Title X funds and thereby is able to demonstrate that its abortion clinic was not supported by the Title X program. April 20, 1971 memorandum from Joel M. Mangel, Deputy Assistant General Counsel, Division of Public Health Grants and Services to Louis M. Hellman, M.D., Deputy Assistant Secretary for Population Affairs.

New Regulations

30. In contrast, the new regulations prevent Title X recipients from:

(1) Providing any post-pregnancy counseling, including non-directive counseling on abortions or abortion referrals (§ 59.8);

(2) Physically co-locating a Title X project with a clinic that performs, counsels on, or refers for abortion (§ 59.9); and

(3) Engaging in any speech deemed to "encourage, promote or advocate" abortion, including lobbying, public addresses, membership in pro-choice organizations, legal action to vindicate the right of abortion, or distribution of

any materials not disparaging of the abortion option. (§ 59.10).

31. The new regulations not only prevent Title X recipients from using Title X funding for non-directive options counseling or abortion referral but also effectively prevent Title X recipients from using their own funds for providing such counseling or related referrals.

32. The new regulations also require recipients to file a special assurance of compliance (which may involve supplying unspecified "documentation") (§ 59.7).

Consequences

[illegible]. Title X grantees will no longer be able to provide the comprehensive, effective, and ethical family planning services contemplated by the Act and historically required by HHS.

34. As a consequence, Title X clients will not receive complete information on family planning options and thus will be deprived of the ability to make an informed decision as to their personal family planning program.

35. In addition, numerous Title X clients will experience medical complications, aggravated illnesses, and irreparable harm as a result of the failure of Title X clinics to counsel or refer to appropriate medical providers with respect to serious medical conditions attendant to pregnancy.

36. Title X clients also will effectively be prevented from exercising their right to an abortion and those Title X patients who do eventually terminate their pregnancies may face increased risks of health complications because of delays occasioned by their ignorance of the legality, availability, risks, timing, and costs of an abortion.

37. Title X grantees will be forced to violate Food and Drug Administration regulations that require labeling that specifies that physicians must discuss the abortion option with pregnant women who have an IUD in place. See 21 C.F.R. § 310.502(b)(1).

38. The physicians and staffs of grantee organizations will have to violate basic medical and ethical precepts, as well as State laws, by withholding full and essential information from their patients.

39. Unable to counsel or refer their patients in accordance with medical ethics, many medical professionals in Title X programs either will leave their programs or disobey the unlawful regulations. Title X programs thus face a substantial loss of medical personnel and chaos in the administration of their programs. Program grantees will be forced to refuse Title X support rather than offer the incomplete, unethical, and dangerous medical care required by these regulations.

40. Title X clinics will become susceptible to malpractice liability because the failure to counsel or refer that is mandated by the new regulations will cause actionable harm to clients. In addition, it is unlikely that Title X recipients will be able to obtain insurance to cover such liability.

41. There will likely be a significant loss of clients -- both paying and subsidized -- as a consequence of the decline in quality of treatment resulting from the regulations.

42. The requirement of separation of family planning services and abortion-related services will result in a significant administrative and financial burden on Title X recipients. The expenses of new property, hiring a new staff, and duplicating administrative expenses may force many clinics simply to give up Title X funding.

Legal Violations

43. The new regulations violate Title X by, *inter alia*: (1) misinterpreting the limited extent of Title X's prohibition on abortion (42 U.S.C. § 300a-6); (2) impeding the principal purposes of Title X, including the provision of a broad range of family planning services, especially to low-income families and adolescents, thorough medical care and consultation, complete disclosure, informed consent, and coordination with other medical services and programs availa-

ble to the Title X population; and (3) effectively preventing Title X recipients from using their own funds to provide such services as they may choose.

44. The regulations also violate the U.S. Constitution, inter alia, in the following ways:

(1) The regulations interfere with the Constitutional right of clients, under Roe v. Wade, 410 U.S. 113 (1973) and its progeny, to make a fully informed decision regarding abortion within the physician-client relationship.

(2) The regulations violate the First Amendment rights of Title X grantees by prohibiting constitutionally protected speech related to and advocating abortion and conditioning the receipt of Title X benefits upon conformance with this prohibition.

(3) The regulations violate the First Amendment rights of women patients to receive the prohibited information.

(4) The regulations violate the First Amendment by imposing a viewpoint discrimination on Title X recipients' expressive activities regarding the issue of abortion.

(5) The regulations violate the First Amendment rights of Title X grantees by preventing them from using their own, non-federal, funds for certain kinds of constitu-

tionally protected legal action and political speech and advocacy.

(6) The regulations are unconstitutionally vague and overbroad as they purport to prohibit all activity which encourages, promotes, or advocates abortion.

45. The new regulations are arbitrary, capricious, abusive of discretion, in excess of authority and not in accordance with law, all in violation of the Administrative Procedure Act, 5 U.S.C. § 552, et seq.

46. The regulations violate the rulemaking requirements of 5 U.S.C. § 553 as well as requirements for prior reviews under Executive Orders.

Injuries

47. If the regulations take effect, plaintiffs will be injured, as follows:

(1) Citizens of the Plaintiff Commonwealth of Massachusetts entitled to Title X services will lose the full benefit of the family planning program as well as their rights to full disclosure and informed consent under State law.

(2) Plaintiffs that are (or are representing) Title X recipients will be required to comply with unlawful regulations, which will not only result in a loss of statutory and constitutional rights but also will force them to reject Title X funding or to experience a loss of staff and clients

and exposure to legal actions that will irreparably injure their family planning projects and their financial viability; and

(3) Plaintiffs who are (or are representing) health care professionals in the Title X program will be required either to quit their positions or violate medical ethics and thereby face possible loss of income and loss of license as well as malpractice or similar actions from clients.

48. Title X clients will face either no Title X program and therefore no services, or a program that will fail to provide them with non-directive counseling and referral and other essential or needed services once they become pregnant.

WHEREFORE, plaintiffs pray that this Court enter an order:

1. Declaring that the new Title X regulations are unlawful.

2. Preliminarily and permanently enjoining implementation and enforcement of the new Title X regulations.

3. Awarding plaintiffs their costs and disbursements in this action, including reasonable attorneys' fees.

4. Retaining jurisdiction over this action for such additional and supplemental relief as may be required.

5. Awarding plaintiffs such other and further relief as the Court may deem just and proper.

Respectfully submitted,
The Commonwealth of Massachusetts
By its Attorneys,

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Date: February 4, 1988

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UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, *
et al., *
Plaintiffs, *
* CIVIL ACTION
v. * NO. 88-0253-S
*
OTIS R. BOWEN, SECRETARY, *
DEPARTMENT OF HEALTH AND *
HUMAN SERVICES, *
Defendant. *

FINAL DECREE

March 3, 1988

SKINNER, D.J.

This cause came on to be heard on the plaintiffs' motion for a preliminary injunction, and a motion for consolidation of said hearing with the hearing on the merits under Fed.R.Civ.P. 65(a)(2) having been allowed, and after consideration of the briefs and arguments of the parties, intervenor and amici, in accordance with the Memorandum and Order filed herewith, it is ORDERED, ADJUDGED AND DECREED that:

1. The defendant in his capacity as Secretary of the Department of Health and Human Services and all officers, agents, employees and attorneys of said Department are enjoined from enforcing or applying the regulations published at 52 Fed.Reg. 2944-2946 (February 2, 1988), including without limitation those

regulations appearing at 42 C.F.R. §§ 59.7, 59.8, 59.9 and 59.10, and the related definitions appearing at § 59.2, against these plaintiffs and the entities they represent, in any manner either directly or indirectly, anywhere within the United States.

2. The defendant shall forthwith notify all affected officers, agents, servants, employees and attorneys of the Department of Health and Human Services of the substance of this decree.

Walter Jay Skinner
United States District Judge

Enter forthwith.
Walter Jay Skinner, USDJ.

UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

COMMONWEALTH OF MASSACHUSETTS, et al.,
Plaintiffs,

v.

OTIS R. BOWEN, SECRETARY, HEALTH AND HUMAN SERVICES,
Defendant

CIVIL ACTION
NO. 88-0253-S

MEMORANDUM AND ORDER FOR FINAL DECREE

March 3, 1989

SKINNER, D.J.

Plaintiffs in this action seek to enjoin the application and enforcement of regulations promulgated by the defendant purporting to carry out the purposes of Section 1008 of Title X of the Public Health Services Act. 42 U.S.C. § 300a-6 (1982). The defendant moved to consolidate the hearing on plaintiffs' motion for a preliminary injunction with the hearing on the merits pursuant to Fed.R.Civ.P. 65(a)(2). At oral argument I denied the motion on the representation of the plaintiffs that there were unresolved questions of fact raised by their several affidavits. Upon examination of these affidavits, however, I conclude that the issues of fact they raise relate to predicted adverse consequences of the regulations, such as their potential for conflict with the medical ethics of some physicians, and to the likelihood of immediate irreparable harm. Plaintiffs argue that Congress could not have intended the predicted consequences and that the regulations therefore violate congressional intent. If unintended consequences were enough to invalidate government action, I doubt that much would survive. Such policy considerations are in any case for Congress, not the courts. Furthermore, immediate irreparable injury is not an issue unless preliminary relief is to be granted. Since the controlling legal issues have been fully briefed and argued, there is no reason to delay a final decision. My order denying the motion to consolidate is VACATED and the motion to consolidate is ALLOWED. A final decree will issue.

A. The Controversy

On February 2, 1988, the Department of Health and Human Services ("HHS") amended the regulations governing the use of federal funds for family planning services. Its purported goal was to assure compliance with section 1008 of Title X:

> None of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning.

42 U.S.C. § 300a-6 (1982). Historically, this section had been interpreted by HHS (and the Department of Health, Education and Welfare, its predecessor) to prohibit the use of federal funds in

the provision of abortions, or in any activity that had the immediate effect of "promoting or encouraging" abortion. The new regulations, which are scheduled to go into effect in two parts, on March 3 and April 4, 1988, significantly expand the scope of prohibited activity.

The new regulations define family planning to exclude all pregnancy care (including obstetric and prenatal care). They provide that a project may not receive federal funds unless it assures compliance with the following rules:

(1) A project may not provide counseling concerning the use of abortion as a method of family planning or provide referral for abortion as a method of family planning. 42 C.F.R. § 59.8(a)(1) (1988).

(2) Once a client is diagnosed as pregnant, she must be provided with a list of providers that promote the welfare of the mother and unborn child.[1] She must also be provided with information to protect the health of the mother and unborn child until the referral appointment is kept. 42 C.F.R. § 59.8(a)(2) (1988).

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[1] At oral argument plaintiffs' counsel pointed out that this language excludes providers that offer abortion counseling or services. Defendant did not contest this interpretation, and I will accept it as conceded.

(3) A project may not use prenatal, social service or emergency medical or other referrals as an indirect means of encouraging or promoting abortion as a method of family planning. 42 C.F.R. § 59.8(a)(3) (1988).

(4) The provision of contraceptive information may not include counseling with respect to abortion as a method of family planning, although it may include information which is medically necessary to assess the risks and benefits of different methods of contraception. 42 C.F.R. § 59.8(a)(4) (1988).

(5) A project may not use Title X funds to promote or advocate abortion as a method of family planning. 42 C.F.R. § 59.10(a) (1988). Prohibited activities include:

a. Lobbying for legislation to increase the availability of abortion as a method of family planning;

b. Providing speakers to promote the use of abortion as a method of family planning;

c. Paying dues to any group that as a significant part of its activities advocates abortion as a method of family planning;

d. Using legal action to make abortion more readily available as a method of family planning;

e. Developing or disseminating any information which advocates abortion as a method of family planning.

(6) A Title X project must be organized so that it is physically and financially separate from all prohibited activities. The Secretary of HHS will determine whether such objective integrity and independence exist based on an individual review of a number of factors and circumstances. 42 C.F.R. § 59.9 (1988).

The regulations also define "Title X project funds," for the first time, to include "all funds allocated to the Title X program, including, but not limited to grant funds, grant-related income or matching funds." 42 C.F.R. § 59.2 (1988). A Title X project has always been required to supplement its federal grant with 10% matching funds. In practice most Title X agencies also charge fees for services to those clients who have the ability to pay, in general generating another 10% of their budget. Therefore, when the regulations limit the use of "Title X project funds," they in fact significantly restrict a project's use of both federal, and non-federal, money.

Plaintiffs allege that the new regulations conflict with Title X and violate the First and Fifth Amendments of the United States Constitution. The only existing precedent consists of an as yet unpublished opinion of Judge Zita Weinshienk on a motion for preliminary injunction in Planned Parenthood Federation of America, et al. v. Bowen, CA 88-2-158 (D. Colo. February 24, 1988). Judge Weinshienk has ruled that the regulations violate the intent of Congress and the constitutional rights of the plaintiffs and has entered a preliminary injunction prohibiting the defendant from enforcing the new regulations or conditioning Title X grants upon compliance with them.

B. Conflict with the Statute

1. General Considerations

The defendant has broad authority to promulgate regulations under Title X. 42 U.S.C. § 300-4(a) (1982). The regulations must be consistent with and must further the purposes of the statute. The particular section of the statute involved in this case is ambiguous. It is not clear whether the prohibition in section 1008 of the use of appropriated funds "in programs where abortion is a method of family planning" is limited to programs which offer or promote abortions, as plaintiffs say, or whether it provides "a wall of separation" between Title X programs and all abortion related activity, as the defendant says. "[T]he question for the court is whether the agency's answer is based on a permissible construction of the statute." Chevron U.S.A. v. Natural Resources Defense Council, 467 U.S. 837, 843 (1984).

In pursuit of their favored constructions of the statute, the parties have tried to run to ground that hardy chimera, congressional intent. In my view, congressional intent must be considered with respect to specific issues raised by the new regulations.

a. Counseling and Referral 42 C.F.R. §§ 59.8(a)

In support of their respective positions about the validity of the counseling and referral restrictions, the parties cite various pronouncements by individual members of Congress. Plaintiffs cite a 1988 committee report accompanying a Continuing Resolution which encouraged continuation of the prior regulations without change. A group of senators and congressmen filed an *amici* brief which indicates their own support and refers to the support of many other congressmen for the regulations as promulgated. These expressions of various individuals are of little assistance in evaluating the intent of Congress as a collective body. *Consumer Products Safety Commission v. G.T.E. Sylvania*, 447 U.S. 102, 118 (1980); *Chrysler Corporation v. Brown*, 441 U.S. 281, 311 (1979). Rep. Dingall's statement in 116 Cong. Rec. 37,375 (1970) is countered by his subsequent letter to the defendant dated October 14, 1987.

Plaintiffs rely on congressional acquiescence to prior longstanding administrative interpretation of the statute by the defendant and his predecessors. In a series of memoranda and opinions from 1970 to the promulgation of these regulations, the Department of Health and Human Services (and the Department of Health, Education and Welfare) consistently interpreted the statute to forbid Title X recipients from conducting activities which had the direct effect of promoting or encouraging abortion, but to allow the clinics to furnish information concerning abortion services. In 1981, departmental guidelines were issued which mandated non-directive counseling on options for pregnant women, including abortion, when a client requested information. Referral for the purpose of abortion was permitted. Memorandum from Joel N. Mangel, Office of General Counsel, HEW, to Louis M. Hellman, Deputy Assistant Secretary for Population Affairs (April 20, 1971); Memorandum of Carol C. Conrad, Office of General Counsel, HEW, to Elsie Sullivan, Office for Family Planning (April 11, 1978); Bureau of Community Health Services, Department of Health and Human Services, Program Guidelines for Project Grants for Family Planning Services (1981).

There is no doubt that Congress was aware of this administrative history and yet resisted attempts to change the statute. If the validity of the departmental interpretation from 1970 to the present were in question, this history would be compelling. Lorillard v. Pons, 434 U.S. 575, 580 (1978); United States v. Correll, 389 U.S. 299, 305-6 (1968). The new regulations represent an abrupt reversal of existing policy which is not positively mandated by section 1008. The plaintiffs argue that since Congress acquiesced in the former policy, the proposed regulations violate Congress' intent and must be struck down. Judge Weinshienk takes essentially the same view. This assumes that Congress operates on a binary system like a computer; i.e., that it has only two choices. Congress gave to the defendant very broad authority to promulgate regulations, and it is an equally valid supposition in my opinion that Congress would tolerate a wide range of administrative policies. Helvering v. Reynolds, 313 U.S. 428, 432 (1941); McCoy v. United States, 802 F.2d 762, 766 (4th Cir. 1986).

While a good case can be made for the plaintiff's proposition that these regulations violate congressional intent, the question is not sufficiently free of doubt in my mind to justify judicial intervention. Accordingly, no injunction will issue to the cited sections of the regulations on the ground of contravention of the intent of the statute, apart from constitutional considerations to be discussed infra.

There is a related doctrine, however, that when an agency decides to change the course of longstanding administrative interpretation, it must justify its action to a greater degree than when it first promulgates regulations:

> A "settled course of behavior embodies that agency's informed judgment that, by pursuing that course, it will carry out the policies committed to it by Congress. There is, then, at least a presumption that those policies will be carried out best if the settled rule is adhered to." Atchison, T. & S.F.R.Co. v. Wichita Bd. of Trade, 412 U.S. 800, 807-808 (1973). Accordingly, an agency changing its course by rescinding a rule is obligated to supply a reasoned analysis for the change beyond that which may be required in the first instance.

Motor Vehicle Manufacturers Association v. State Farm Mutual, 463 U.S. 29, 41-42 (1983).

The defendant puts forth two reasons for the changes in his agency's policy. First, he argues that the new interpretation is mandated by the statute. This clearly is not the case. Second, the defendant argues that the regulations are needed to assure compliance with the mandate of section 1008 that the provision of abortion services be kept separate from Title X funds. The defendant must show that this explanation is supported by the evidence before the agency. Motor Vehicle Manufacturers Association v. State Farm Mutual, 463 U.S. at 43.

All the evidence before the defendant indicated that Title X clinics were substantially complying with program requirements. Family Planning Act Reauthorization, 1985:

Hearings before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce, 99th Cong., 1st Sess. 189 (1985) (statement of Dr. James O. Mason, Acting Assistant Secretary for Health, HHS) ("the prohibition against abortion was well-known at the level of the family planning clinics, and it was being honored"); *Family Planning Act Reauthorization, 1985: Hearings Before the Subcomm. on Health and the Environment of the House Comm. on Energy and Commerce*, 98th Cong., 2d Sess. 472 (1984) (statement of Margaret M. Heckler, Secretary, HHS) (same); Comp. Gen. Rep. No. GAO/HRD-82-106 (1982) ("GAO found no evidence that title X funds had been used for abortions or to advise clients to have abortions"); Memorandum from Richard P. Kusserow, Inspector General, to Edward N. Brandt, Jr., Assistant Secretary for Health (November 18, 1982) ("Grantees were generally aware of the legal prohibitions against using Title X grant funds for lobbying, contributions to third parties, and/or abortion related activities").

The agency can only point to the General Accounting Office's suggestion in its 1982 report that HHS issue regulations to clarify the standards under section 1008. Comp. Gen. Rep. No. GAO/HRD-82-106 at iv. This can best be interpreted, however, as a suggestion that HHS codify its longstanding policy into regulations, so as to reduce any confusion about program requirements. There was no suggestion that significantly more stringent regulations need be issued in order to assure compliance.

The agency also refers, in its commentary to the new regulations, to a number of letters received by the agency from individual clients of Title X clinics who claimed that they were pressured into undergoing abortions which they did not want, and subsequently came to regret. 53 Fed. Reg. 2924-25 (February 2, 1988). In light of the anecdotal nature of these letters, and their inconsistency with the GAO report and Secretay Heckler's testimony, they are not reliable evidence upon which to base such a significant policy reversal.

In Motor Vehicle Manufacturers Association, supra, the Court refused to enforce regulations which reversed prior administrative policy and remanded the matter to the agency to amend the regulations to conform to the record. I suppose an option in this case would be to stay the effective date of the HHS regulations to give the executive branch an opportunity to amplify the record justifying its policy change. In view of the constitutional considerations discussed infra, however, such a procedure would be pointless.

b. Lobbying and Advocacy
42 C.F.R. § 59.10(a)

The restrictions on lobbying and advocacy are for the most part a codification of prior administrative interpretation. A 1978 memorandum from the HEW Office of Legal Counsel indicated that Title X funds could not be used for advocacy activity designed to promote abortion as a method of family planning. Memorandum from Carol C. Conrad to Elsie Sullivan (April 11, 1978). Congressional acquiescence in these restrictions, despite repeated opportunity to amend the statute, can fairly be construed as an indication that the restrictions are consistent with congressional intent. Lorillard v. Pons, 434 U.S. at 580; United States v. Correll, 389 U.S. at 305-06.

The new regulations, of course, have a wider impact because of the new (and unwarranted) definition of "Title X Project Funds." The new regulations prohibit the use of non-federal funds for lobbying as well as federal funds, and also prohibit membership in or support of any organization which engages in lobbying. While this extension is not so radical a change as to warrant a conclusion that the new regulations violate the intent of Congress, the constitutional implications are serious, as discussed *infra*.

c. Physical and Financial Separation 42 C.F.R. § 59.9

The program integrity regulations promulgated by HHS require that a Title X grantee be physically separated from any program that performs activities prohibited under the statute. 42 C.F.R. § 59.9 (1988). There is no indication in section 1008 that Congress intended to restrict the types of projects with which a Title X recipient could associate, or to place limitations on the physical proximity or the sharing of personnel between Title X projects and unrelated programs which may provide abortion services. The statute merely restricts some uses of appropriated funds.

The legislative history of Title X offers persuasive evidence that the program integrity regulations run contrary to congressional intent underlying section 1008. The original Conference Report on Title X stated that the abortion prohibition was "not intended to interfere with or limit programs" supported with other than Title X funds. H.R. Conf. Rep. No. 1667, 81st Cong., 2d Sess. (1970), reprinted in 1970 U.S. Code Cong. & Admin. News 5082. Furthermore, the Report of the Senate Labor and Public Welfare Committee for the 1975 reauthorization of Title X provided:

> The Committee encourages the use of funds otherwise authorized by this bill for the provision of family planning services, not only in specialty clinics, but, where such facilities do not exist or are impractical, in entities devoted to comprehensive health care for

> low-income families....[I]t is essential that there be close coordination and, whenever possible, integration of family planning services into all general health care programs.

S. Rep. No. 63, 94th Cong., 1st Sess. 65-66 (1975), *reprinted in* 1975 U.S. Code Cong. & Admin. News 528.

The contemporaneous and continuous agency interpretation was consistent with this view.[2] Indeed, the statute itself mandates a state plan for a "*coordinated and comprehensive* program of family planning services" as a prerequisite to any Title X grant. 42 U.S.C. § 300a(a) (1982) (emphasis added). The requirement of physical separation runs contrary to this congressional emphasis on coordinated and integrated health care services.

Defendant argues that the validity of the program integrity regulations is not presently ripe for review. The regulations require that the Secretary make an individual determination of program integrity for each grant recipient. They require physical and financial separation, and articulate a number of factors upon which the Secretary may rely in making his decision. Defendant argues that until the regulations are construed and applied, the question of their validity should not be decided.

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[2] The agency position, until these regulations were promulgated, was that as long as funds were kept separate, physical separation was unnecessary. In 1971, the Office of General Counsel of the Department of Health, Education and Welfare indicated in an opinion letter that under most circumstances, a hospital providing abortions for family planning purposes would be qualified to receive Title X funds for the operation of a separate family planning clinic, as long as funds were kept separate. Memorandum from Joel M. Mangel to Louis M. Hellman at 3 (April 20, 1971).

The Supreme Court has articulated a ripeness test that directs courts to evaluate two criteria: "the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." Abbott Laboratories v. Gardner, 387 U.S. 136, 149 (1967). The appropriateness of an issue for judicial review depends upon a number of factors, including whether the agency action is final, whether the issue presented requires additional factual development, and whether further administrative action is needed to clarify the agency's position. Action Alliance of Senior Citizens v. Heckler, 789 F.2d 931, 940 (D.C. Cir. 1986).

Defendant argues that this part of the regulations will be applied on a case-by-case basis, and, therefore, that it is premature to adjudicate its validity. I see no need to litigate each instance separately. These are the defendant's regulations and it is reasonable to assume that he will do what he says he will do, which is to require physical separation. This clearly runs counter to congressional policy favoring coordination and integration of health care programs. It will be enjoined.

d. Definition of "Title X Project Funds" 42 C.F.R. § 59.2

The proposed regulations define "Title X project funds" to include "all funds allocated to the Title X program, including, but not limited to grant funds, grant-related income or matching funds." The effect is to put the use of matching funds and the income from fee paying clients under the same restrictions as funds appropriated by Congress. There is no basis for this definition in the statute and no legislative or administrative history to support it. I assume that this beginning exercise in political redefinition ("think-speak" in Orwellian terms) was designed to preempt the constitutional argument to be discussed hereinafter. In my opinion, it is unwarranted. The legislative concern was with the use of public money.

C. Constitutional Considerations

Plaintiffs challenge the new regulations on First and Fifth Amendment grounds. Because the limitations on counseling and referral and the limitations on lobbying and advocacy require different constitutional analyses, I will address each separately.

1. Counseling and Referral

Under the new regulations, a Title X project may not provide abortion counseling or referral. 42 C.F.R. § 59.8(a)(1)-(3) (1988). It may not counsel with respect to abortion as a method of family planning when it provides contraceptive information. 42 C.F.R. § 59.8(a)(4) (1988). Any project which conducts any of these activities is ineligible for a Title X grant. 42 C.F.R. § 59.7 (1988). If an organization conducts these activities in a separate program, the Title X project must be physically and financially separate from the prohibited activities. 42 C.F.R. § 59.9 (1988).

The restriction on abortion counseling and referral extends to an entire Title X "project," and to all Title X "project funds," as redefined by the regulations. As a result, even a project which uses non-federal funds, either matching funds or private funds, to provide abortion counseling or referral, is made ineligible to receive a Title X grant.

Plaintiffs argue that these restrictions violate the First Amendment to the United State Constitution. Abortion referral and abortion counseling are constitutionally protected speech under the First Amendment. Bigelow v. Virginia, 421 U.S. 809 (1975). Denying an otherwise eligible organization a grant because it provides abortion counseling or referral, even with non-federal funds, constitutes an impermissible penalty for the exercise of a constitutionally protected right. The government may not penalize an individual for exercising his or her First Amendment rights, even if the penalty is the denial of a government benefit:

> [E]ven though a person has no "right" to a valuable governmental benefit and even though the government may deny him the benefit for a number of reasons, there are some reasons upon which the government may not rely. It may not deny a benefit to a person on a basis that infringes his constitutionally protected interests -- especially, his interest in freedom of speech.

Perry v. Sindermann, 408 U.S. 593, 597 (1972).

The government argues that it may constitutionally choose not to subsidize certain activities. In Maher v. Roe, 432 U.S. 464 (1977), and in Harris v. McRae, 448 U.S. 297 (1980), the Supreme Court was presented with challenges to Medicaid systems that did not subsidize abortion. The Court held that the state may make a value judgment favoring childbirth over abortion, and may implement that value judgment by the allocation of public funds. In essence, the Court said the government had no obligation to subsidize abortion, or to subsidize abortion and childbirth equally. In both cases, however, the Court acknowledged the difference between a refusal to subsidize and a penalty. The Court noted that refusing all Medicaid benefits to a woman because she had an abortion, although the practice might "promote childbirth," would be an impermissible penalty for the exercise of a constitutionally protected right. *Harris v. McRae*, 448 U.S. at 317, n.19; *Maher v. Roe*, 432 U.S. at 474-475, n.8.

The defendant argues that the HHS regulations are permissible under *Maher* and *Harris* because they merely reflect the government's legitimate decision not to subsidize certain activities. The defendant ignores, however, the crucial difference between a failure to subsidize and a penalty for the exercise of constitutional rights. The HHS regulations go beyond a mere refusal to subsidize. Under the new regulations, a Title X project could be denied a grant for which it would otherwise be eligible, solely because its non-federally funded activities include abortion referral and counseling. As a result, the regulations constitute an unconstitutional penalty for the exercise of First Amendment rights. *See* *Reproductive Health Services v. Webster*, 662 F. Supp. 407, 427-28 (W.D. Mo. 1987) (invalidating as unconstitutional provisions which prohibit the expenditure of public funds, actions of public employees, or use of public facilities, for the purpose of, *inter alia*, counseling a woman to have an abortion); *Planned Parenthood v. State of Arizona*, 537 F. Supp. 90 (D. Ariz. 1982) (invalidating as unconstitutional a bill which prohibited state money from being given to agencies which offer abortion counseling or referral), *rev'd and remanded*, 718 F.2d 938 (9th Cir. 1983), *aff'd after remand*, 789 F.2d 1348 (9th Cir. 1986), *aff'd sub nom. Babbitt v. Planned Parenthood*, ___ U.S. ___, 107 S.Ct. 391 (1986).

Furthermore, the restriction on speech imposed by the defendant's regulations is content-based. These regulations, individually and as a whole, have the purpose and effect of severely limiting speech by Title X recipients on one topic: abortion as a method of family planning. Such a content-based distinction violates the First Amendment: "[A]bove all else, the First Amendment means that government has no power to restrict expression because of its message, its ideas, its subject matter, or its content." *Police Department of Chicago v. Mosley*, 408 U.S. 92, 95 (1972).

The new regulations cannot withstand the "critical scrutiny" demanded by accepted First Amendment and equal protection principles. *First National Bank of Boston v. Bellotti*, 435 U.S. 765, 786-87 (1978). The government has not suggested a compelling governmental interest that would justify the content-based distinction. If a regulation is narrowly tailored to achieve a compelling governmental interest, incidental restrictions on speech will on occasion be tolerated. *United States v. O'Brien*, 391 U.S. 367, 377 (1968). In this case, however, the regulations are specifically designed to suppress speech, and particularly directed at the suppression of one viewpoint. As a result, they run directly contrary to the dictates of the First Amendment.

In its attempt to implement a health care policy which promotes childbirth, the defendant has devised a system which rests in large part on keeping Title X clients in ignorance. The First Amendment embodies a different philosophy:

> There is, of course, an alternative to this highly paternalistic approach. That alternative is to assume that this information is not in itself harmful, that people will perceive their own best interests if only they are well enough informed, and that the best means to that end is to open the channels of communication rather than to close them.

Virginia Pharmacy Board v. Virginia Consumer Council, 425 U.S. 748, 770 (1976).

2. Lobbying and Advocacy

The prohibitions in 42 C.F.R. § 59.10 on activities that encourage, promote, or advocate abortion clearly implicate the First Amendment. Even the Secretary concedes, in his brief on this motion, that lobbying and other advocacy activities are at the "core" of the First Amendment. While the constitutional underpinning for the right to have an abortion is relatively abstruse, see Roe v. Wade, 410 U.S. 113 (1973), and remains the subject of learned discourse, the right to talk about abortion is firmly and expressly guaranteed. Prior to Roe v. Wade, some states permitted abortions and some did not. The discussions that led to these legislative policies were clearly protected by the First Amendment, and such discussions remain so today.

The new regulations reflect more than a mere refusal to subsidize protected First Amendment activity. The regulations refuse funding to any organization that engages in abortion-related advocacy, even if non-federal funds, such as matching grants or private funds, are used. In addition, an organization that supports lobbying or other advocacy activity with funds wholly separate from its Title X grants must physically separate this activity from its Title X project.

The government argues that the regulations are constitutional under the holding of the Supreme Court in Regan v. Taxation with Representation, 461 U.S. 540 (1983). In that case, the Court upheld a statute which denied the right to obtain tax deductible contributions to organizations that engage in substantial lobbying. The Court held that Congress has a right to refuse to pay for lobbying out of public money. It pointed out that an organization which engaged in lobbying was not penalized, because it could locate all of its non-lobbying activity in a separate corporate structure. The separate, non-lobbying corporation could then receive tax deductible contributions. The Court also held that the lobbying restriction did not violate the equal protection component of the Fifth Amendment, even though veterans' associations were allowed by statute to engage in substantial lobbying activity while receiving tax deductible contributions.

Applying the same reasoning to this case, the government says that it may constitutionally choose not to subsidize lobbying. It argues that because family planning projects can place their lobbying activities in a separate organizational structure, the regulations restricting lobbying are constitutional. This argument is unpersuasive for two reasons. First, the regulations impose an additional requirement of physical separation which, however it would ultimately be implemented by the Secretary, is unduly burdensome and not narrowly tailored to meet the government's goal of not subsidizing advocacy activity. See Regan v. Taxation with Representation, 461 U.S. at 554 (Blackmun, J., concurring) (emphasizing that the I.R.S. required only separate incorporation and separate record-keeping, and questioning whether more burdensome requirements would be constitutional).

More importantly, this case is distinguishable because the lobbying restriction in the HHS regulations is content-based. The Supreme Court in Taxation with Representation specifically said: "The case would be different if Congress were to discriminate invidiously in its subsidies in such a way as to 'aim at the suppression of dangerous ideas.'" Regan v. Taxation with Representation, 461 U.S. at 549. It upheld the classification only because it found "no indication that the statute was intended to suppress any ideas or any demonstration that it has had that effect." Id.

The advocacy restrictions in the HHS regulations are clearly designed to suppress a certain idea: they restrict only advocacy that promotes abortion as a method of family planning. As discussed previously, such a content-based distinction violates the First Amendment. Because the restrictions are not narrowly tailored to serve any legitimate governmental interest, they violate both the First Amendment and the equal protection component of the Fifth Amendment to the United States Constitution.

3. Impact on the Right of Privacy

While the relationship of these regulations to the liberty interest protected by the Fifth and Ninth Amendments is more attenuated than to the First Amendment, it is still significant. The right to elect an abortion in the first trimester is constitutionally protected from unduly burdensome governmental interference. Roe v. Wade, 410 U.S. at 163; Maher v. Roe, 432 U.S. at 473-74 (1977). In my opinion, a governmentally imposed block on the flow of neutral information bearing on abortion is an impermissible burden on the presently recognized rights of a pregnant client of a Title X clinic. An example of such an improper burden is the prohibition against non-directive referrals to health providers who offer abortion counseling or services.

D. Conclusion

If these regulations were to be considered solely on the basis of congruence with legislative intent, or solely on the basis of constitutional violation, some attempt at severance might be in order. As the foregoing discussion establishes, however, there is very little in these regulations which does not offend one standard or the other. Severance would save practically nothing. The attempt would be inappropriate. See Thornburgh v. American College of Obstetricians & Gynecologists, 476 U.S. 747, 764 (1986) ("The radical dissection necessary for this would leave little resemblance to that intended..."). The regulations promulgated on February 2, 1988 by the Department of Health and Human Services pursuant to Title X of the Public Health Service Act as a whole violate both congressional intent and rights protected by the Constitution. A final decree shall enter enjoining their enforcement.

I have the authority to enjoin the defendant from implementing the regulations against any of the plaintiffs in this action. *See* *Califano v. Yamasaki*, 442 U.S. 682, 702 (1978) (Scope of injunctive relief includes that which is necessary to afford relief to all complaining parties). This court has national jurisdiction in federal question cases. *Omni Capital International v. Rudolph Wolff & Co., Ltd.*, 56 U.S.L.W. 4031 (December 8, 1987). Two plaintiffs in this action, the National Family Planning and Reproductive Health Association ("NFPRHA") and the American Public Health Association ("APHA"), are national organizations suing in their representative capacities. NFPRH represents nearly 75% of Title X recipients and 285 subgrantees across the country. The Massachusetts Attorney General appears for all Title X recipients in Massachusetts. Because the standing of these plaintiffs to sue in their representative capacity has not been challenged, they may properly assert the rights of their constituents. *See* *Hunt v. Washington Apple Advertising Commission*, 432 U.S. 333, 343 (1977) (setting forth standards for determining an association's standing to sue in its representative capacity); *Planned Parenthood Federation v. Schweiker*, 559 F. Supp. 658, 664 (D. D.C.) (concluding NFPRHA has standing to sue as a representative of a class of member affiliate family planning clinics), *aff'd*, 712 F.2d 650 (D.C. Cir. 1983).

The Secretary is therefore enjoined from implementing the regulations promulgated on February 2, 1988 pursuant to Title X of the Public Health Service Act, as against any of the plaintiffs in this action or any of the entities they represent, wherever situated.[3] I assume that the Secretary, as a responsible public official, will apply this judicial determination evenhandedly to all similarly situated entities in the United States. *See* *Feld v. Berger*, 424 F. Supp. 1356, 1363 (S.D. N.Y. 1976). *Accord* *Vulcan Society of the New York City Fire Department, Inc. v. Civil Service Commission*, 490 F.2d 387, 399 (2d Cir. 1973); *Stanton v. Board of Education*, 591 F. Supp. 190, 195 (N.D. N.Y. 1984).

A final decree shall issue forthwith.

Walter Jay Skinner
United States District Judge

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[3] If the plaintiffs wish to amplify this order by submitting a list of the agencies they represent, I will amend the final decree by appending that list.

ACLUF
AMERICAN CIVIL LIBERTIES UNION FOUNDATION

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July 29, 1988

Rep. Henry Waxman
U. S. House of Representatives
Committee on Energy and Commerce
Subcommittee on Health and Environment
2415 Rayburn HOB
Washington, DC 20515

Re: Title X Demonstration Grant to Strafford County Prenatal and Family Planning Program

Dear Rep. Waxman,

It has recently come to my attention that the subcommittee which you chair received testimony during its hearings on reauthorization of the Title X family planning program from Ms. Joanne Gaspar, a former official of the Department of Health and Human Services, to the effect that the Strafford County (N.H.) Family Planning Program misused a Title X demonstration grant for the preparation of a sexuality education curriculum. I understand that a copy of the curriculum, Mutual Caring, Mutual Sharing, was also made part of the record as an "example" of misuse of funds.

Because that testimony and the curriculum itself are part of the record of your hearings, and because the family planning program, which I represent, had no opportunity to respond to those charges at the hearings, I request that this letter, with its enclosures, also be made part of the record.

The charge of misuse of funds made against my client is baseless. Subsequent to Ms. Gaspar's testimony, we submitted to DHHS, at its request, a 93-page statement, plus exhibits, outlining the manner in which the Mutual Caring, Mutual Sharing curriculum was prepared. This narrative describes the process by which the themes of the curriculum were developed, including the theme of undercutting stereotyped gender role pressures and the fear of being labeled homosexual. It makes clear that the level of community input required by federal regulations for the development of curricular materials funded under Title X was greatly exceeded by the grantee in this case; and in fact the themes which later became controversial were brought to the attention of the project directors by members of the very community for which the materials were developed.

The sexuality education curriculum developed by my client during the course of the New Directions for Young Men (NDFYM) Project was the product of intensive community consultation and feedback from the beginning of the initial contract term. The ideas which have been made the subject of so much recent controversy arose out of consultation with members of this community and were systematically approved, indeed applauded, by state officials themselves. One of these ideas is recognition of the correlation between extreme gender role pressures (including "homophobia," the fear of being labeled homosexual) and contraceptive irresponsibility in adolescent males.

During the first year of the grant the Project Director conducted primary and secondary research on the underlying causes of male sexual irresponsibility. Extensive consultation with professional educators, psychologists and other experts in adolescent reproductive health issues informed these research efforts. During these consultations, NDFYM Project staff were told, repeatedly and by a cross-section of those consulted, that intense gender role pressures experienced by adolescent males were one major cause of sexual irresponsibility, i.e. that fear of being perceived as not "macho" or as unable to "get a girl pregnant" was an enormous pressure which operated on young males to promote irresponsible sexual and contraceptive behavior. Further, Project staff were told, repeatedly and by a number of independent sources, that one of the clearest symptoms of this fundamental problem was the terror felt by young males at the possibility of being labeled gay. A dramatic example of this correlation occurred in the Project's first year, when one teenage father told the Project Director, "at least [fatherhood means] we're not gay."

Thus, from the community of professionals for whom the curriculum was intended, NDFYM Project staff received the message that a sexuality education program grappling with homophobia, and with the extreme social pressures it represents, would be a highly effective strategy for seeking to defuse the pressure to demonstrate "machismo" through reproduction. As a consequence, it was hoped, participants in such a program would become more responsible for their sexual behavior and more involved in averting unwanted consequences of sexual activity such as pregnancy.

The initial research phase of Project was followed by further consultation, testing and validation of the central premise which led to development of the curriculum: that effective intervention to modify patterns of sexual irresponsibility by teenage males must address the crippling gender role pressures experienced by these young men. Confronting the issue of homophobia was one, but only one, aspect of the proposed approach. It was an aspect, however, which was never hidden from the hundreds of persons who were part of the community input and review process. Indeed, the innovative nature of this approach led to repeated presentations by the Project Director to a wide spectrum of audiences, including professional conferences, high school teachers and students, parents, mental health and reproductive health care workers, and state and federal health department officials. Without exception, the approach taken by the Project to contraceptive irresponsibility and to homophobia was extremely well received. Commendation followed commendation, providing repeated community validation for utilization of this approach.

In the last phase of the grant period, after the curriculum was drafted, it was pilot tested in a two-part process. Adult trainers were recruited to lead discussions and be trained by the Project Director. Then, pilot sessions were run for local teenagers who, with parental consent, participated in a course taught by trained educators in accordance with the curriculum (the curriculum was written for the trainers and not the students; students themselves did not receive copies). State health department officials also reviewed the curriculum at this stage, and sat in on training and pilot sessions. Feedback from participants as well as sate officials was overwhelmingly positive. There were no objections from the participants or their parents as to the now disputed parts of the curriculum. (See attached letter.)

In light of the extensive research and community and professional consultation which preceded the development of the curriculum, and the validating process of pilot testing the curriculum, it is no surprise that state officials, in consultation with a state-appointed community advisory committee of its own, nominated the NDFYM Project for the National Health Promotion Award administered by the United States Department of Health and Human Services. (See attached letter.)

In sum, during the three-year life of the Project, hundreds of persons were contacted for the purpose of drawing on their expertise and experience. The federal regulations requiring community input were more than adequately complied with, and the content of the curriculum reflects the consensus of opinion in the professional literature on sexuality.

We appreciate the opportunity to respond to these allegations.

Yours truly,

Nan Hunter

Nan D. Hunter

STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH SERVICES

Mary Mongan
Commissioner

William T. Wallace, Jr., M.D., M.P.H.
Director
Division of Public Health Services

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6 Hazen Drive
Concord, NH 03301-6527
(603) 271-4551

January 15, 1988

Ruth Abad
NH Bureau of Maternal
& Child Health
6 Hazen Drive
Concord, NH

Dear Ruth:

I am pleased to inform you that the New Directions for Young Men Program has been selected by the New Hampshire Review Committee as one of the five community health promotion programs which the Division of Public Health Services is nominating for the national competition to recognize exemplary local programs.

All nominees will receive a certificate of merit from the Secretary of Health and Human Services. Additionally, all applications nominated from participating States will be reviewed by national consultants for the Outstanding Achievement Award category. State nominations are not ranked so that all submissions are reviewed independently on their merit against all other applications.

Our congratulations to you and your associates for providing a valuable health promotion program in your community. We are proud to have your application represent New Hampshire in the national competition.

As soon as we are informed of the outcome of the competition, we will contact you.

Sincerely,

William T. Wallace

William T. Wallace, Jr., M.D., M.P.H.
Director
Division of Public Health Services

WTW/pc
3235m

PUBLIC HEALTH

STATE OF NEW HAMPSHIRE
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January 5, 1987

Chuck Rhoades, Director
The Clinic
P.O. Box 791
50 Chestnut Street
Dover, NH 03820

Dear Chuck,

Thanks for forwarding us copies of the Mutual Caring, Mutual Sharing Curriculum. You and Copper deserve a lot of credit for the nuturing and commitment you put into the development of MC, MS.

I'm sure with the contacts you have already made and the Center for Health Training's proposed resource guide on male involvement materials, the curriculum will be well received.

Take care.

Sincerely,

Ruth

Ruth Abad

RA/sc

PUBLIC HEALTH